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COUNCIL ON SOCIAL WORK EDUCATION

CONTINUING EDUCATION FOR GERONTOLOGICAL CAREERS

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By Roberta R. Greene

ORIGINAL

Continuing Education for Gerontological Careers

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PREFACE

In 1975, Dr. Robert Butler in his Pulitzer Prize winning book, WHY SURVIVE? BEING OLD IN AMERICA, questioned the nation's commitment to the elderly and brought attention to the inadequate resources and services for older adults. More than a decade later, despite considerable efforts by a dedicated core of professionals, mental health and social services for the elderly continue to lag behind. The Council on Social Work Education is among those professional organizations that have addressed this issue by producing curriculum materials for social workers and other mental health professionals working with the aged and their families. This training manual which was made possible by the Administration on Aging, Office of Human Development Services, Department of Health and Human Services, is part of that effort. Its content reflects and is an outgrowth of the social work community's dedication to quality human services for older adults.

The goal of compiling a training manual which would contain a core or basic curriculum for individuals pursuing careers working with the aged and their families was accomplished with the assistance and cooperation of many. Special thanks are in order to the ten members of the Advisory Committee who gave of their time to recommend and review curriculum content. They include: Dr. Ruth Dinkle, Case Western Reserve University, Dr. Louis Lowy, Boston University, Ms. Charlotte Mahoney, National Association of Social Workers, Ms. Barbara Newsome, Norfolk State University, Ms. Margaret Rafner, Jewish Social Service Agency, Dr. Robert Schneider, Virginia Commonwealth University, Dr. Susan Sherman, State University of New York at Albany, Professor Darrell Slover, Syracuse University, Dr. Barbara Solomon, University of Southern California, and Dr. Thomas Walz, University of Iowa.

A thank-you should also be extended to the faculty and staff of the 10 universities that served as demonstration sites across the nation. They provided special trainers who attended a two-day seminar and lent their expertise to comment on teaching resources. This was followed by pilot training sessions at each school which allowed for over 650 to attend continuing education courses based on the draft curriculum. The comments of the trainers and trainees clearly contributed to the outcome of the final training manual. Those universities participating included: Boston University, Michigan State University, Ohio State University, Rhode Island College, University of California - Los Angeles, University of Hawaii, University of Maryland at Baltimore, University of Tennessee - Knoxville, Virginia Commonwealth University, and West Virginia University.

Special thanks are in order to Ms. Donna DeAngelis who served as Project Director while at CSWE and continued with the project after joining the staff of the Lupus Foundation. Her assistant, Teresa Fincheo, who not only worked on the manuscript but helped to analyze data, should also be thanked. Drs. Diane Bernard and Eunice Shatz who brought the document through to completion as well as Ms. Cynthia Montgomery who worked on the final production, all deserve a special note of thanks.

INTRODUCTION

The quality of human services provided to the elderly depends directly on the knowledge, skills, and committment of those providing care and services. Recognizing that properly trained professionals are the key to effective and efficient service delivery to the elderly and their families, the 1981 White House Conference on Aging recommended that "all personnel involved in the delivery of such services should be required to have gerontological and/or geriatric training...". This training manual, part of a national curriculum project of the Council on Social Work Education, funded by the U.S. Department of Health and Human Services, Administration on Aging, is a response to that challenge.

Meeting the need for qualified professionals to work with and for the aged has been a concern for several decades. Despite substantial advances in the number of personnel educated to assume positions working with the elderly and their families, shortages still exist and more are forecasted. At a September, 1986 hearing held by the National Institute on Aging an increased demand for geriatric services through the year 2020 was documented. At that time, the National Association of Social Workers testified that there is a rapidly growing number of high risk older adults who may require human services, with a decreasing pool of professionally trained geriatric social workers to serve them. It was pointed out that mental health clinics, hospitals, nursing homes, and family service agencies are already experiencing an underutilization of social services, while nutrition sites, multipurpose senior centers, adult protective service departments, area offices on aging, and community-based case management programs will continue to need more trained personnel.

The future demand for human services is related not only to the increased number of elderly people but to the changing age structure and socioeconomic picture of the U.S. population. It is a well known fact that the number of elderly persons over 65 has grown dramatically since the turn of the century, and for the next 50 years, will continue to grow more rapidly than the total population. According to the U.S. Bureau of the Census, in 1982, 11 percent of all Americans were 65 and older; by the year 2025, a projected 19 percent of the total population will be elderly. A less known fact is that the 75-plus group is currently the fastest growing segment of the American population. The 85-and-over group is growing especially rapidly, up 165 percent from 1960 to 1982 (Taeuber, U.S. Census Bureau, 1983). By the year 2050, the proportion of those 85 years and older is projected to jump from 1 to 5 percent of the total population.

As the elderly population grows, most will lead healthy productive lives; however many at risk individuals and their families will require services. For example, older adults in the most upper age brackets are often frail, and therefore may have a greater need for social services, income maintenance, housing, health and personal care services (AARP, 1984, New York Times, 1984). The probability that older women will live longer than men and experience differences in social and economic conditions places many of them at risk. Another high risk group is the minority aged. Their disadvantages status as it relates to income, housing, employment, and health also leads to high risk. These projected social and demographic factors make it even more imperative to assure the highest level of trained personnel.

Determining the education and training needs for careers in the field of aging is not an easy matter. There has been considerable debate in universities, schools and colleges, and in governmental agencies, such as the Administration on Aging, the National Institute of Aging, and the National Insititute of Mental Health about what constitutes the core body of knowledge, skills, and attitudes necessary to work with the elderly and their families. In 1977, a joint study by the Gerontological Society of America and the Association for Gerontology in Higher Education sought to investigate the existence of a core knowledge base for all people working in the field of aging. Consensus was reached among the project's panel of experts that there is a common core of information that all professionals working in the field of aging should have. There was agreement that those working with the elderly should understand aging as a natural experience that entails normal changes in biological, psychological, and health functioning. For social work, specialized training was seen also as including public policy for the aged, legislation affecting the elderly, planning and program development, attitudes toward aging, marital and family relationships, and the socio-cultural context of aging (The Gerontologist, Vol. 20, June 1980). This view of the core curriculum set a backdrop for determining the content of "Continuing Education for Gerontological Careers".

In developing the curriculum materials for "Continuing Education for Gerontological Careers" a number of activities were undertaken to determine what best to incorporate in the curriculum. These included conducting three national surveys to inquire about continuing education needs in gerontology (one of social work practitioners, one of family service agency supervisors and/or directors, and another of continuing education programs directors), meeting with an advisory committee comprised of educators and practitioners to elicit ideas for core content, convening a cadre of expert trainers to review the materials to use at the demonstration sites, piloting the draft training modules with well over 600 trainees at ten universities and revising the final curriculum based on this feedback. The ten learning modules developed as a result are: 1) Selected Biological Aspects of Aging: Dementia, Psychopharmacology, 2) Multifaceted Gerontological Assessment: Learning to Evaluate the Elderly Client's Functional Capacities, 3) Intergenerational Family Dynamics: Family Development, Individualization and Separation, 4) Values and Ethical Issues in Working with the Aged and their Families, 5) Enhancing Support Networks, 6) The Long-Term Care Continuum: Community Living and Institutionalization, 7) Cross-Cultural Communications with Diverse Ethnic and Minority Elderly, 8) Group Processes in Work with the Aged, 9) Sexuality in Later Life, 10) Social Policy and Change and the Elderly: Advocacy and Empowerment.

Collectively, the modules constitute a continuing education package/program. Each module may be used, however, as a separate instructional course. As a free standing unit each contains sections on training objectives, definitions of terms, human behavior, research, methods of intervention, policy, practice implications, training suggestions, annotated bibliography, supplemental bibliography, and an appendix of learning materials.

In as much as the content of each module can constitute a comprehensive learning experience for the trainee, program planners and trainers may select from among the modules, and even within modules, (selecting out specific objectives) to meet special learning needs of groups of trainees.

In using each module it is important for the trainer to weigh the amount of time/emphasis that will be given to each of the learning areas, namely human behavior, research, policy and methods of intervention. The objective of the sections on human behavior is to help trainees better understand that human experience can best be understood by using appropriate and up-to-date theories as a guide. The goal is to transmit the idea to practitioners that they need to possess a framework for accessing clients and selecting intervention strategies, and to provide some of those key concepts.

It is the objective of the research section to expose practitioners to current research findings and to relate the results of these studies directly to their day-to-day practice. It is generally observed that human service professionals are more interested in "doing," working directly with people. Therefore, they may not be as likely to read research studies nor to view research results as useful to the problem solving or treatment planning process. For that reason, continuing education courses provide an ideal opportunity to expose practitioners to applied research.

It is the objective of the section on policy to heighten awareness and to encourage trainees to become more active in policy issues. In order to deal with the social inequities facing the elderly and to assure access to services, continuing education courses must develop a perspective on how to think from "case-to-case," and foster the skills necessary for practitioners to act as advocates.

The sections in the modules on methods of intervention are designed to enable trainees to employ a wider spectrum of treatment modalities. These range from interventions aimed at making social institutions more responsive to the needs of people, to therapies focused on developing individual insight. The goal is to provide the opportunity to explore "new" methods that trainees can take back to the work place.

There are other factors to consider in selecting certain modules or sections there of for emphasis. Among the many factors to consider are whether the trainees are engaged in practice in rural or metropolitan geographical areas, the type of practice setting such as hospice, hospital, nursing home or senior center, years of practice experience, previous employment with client population, timeliness of policy issues, etc. In large measure, the trainees are probably the best judge of their learning needs, and their views should be solicited.

Finally, it is hoped that trainers will use these educational materials to impart a philosophy of practice which recognizes the right to self-determination for the older adult and his or her family. In addition, it is hoped that through the training experience participants come to consider how they may influence the environments in which older adults live, so that old age may be a time of dignity and which continues to provide an opportunity for growth.

SELECTED BIOLOGICAL ASPECTS OF AGING, DEMENTIA, PSYCHOPHARMACOLOGY

This module is designed to help human service professionals better understand the nature of dementing illnesses, a degenerative process bringing about a diminution in cognitive functioning. It presents guidelines for distinguishing between normal age-related changes and pathological processes, and for assessing reversible and irreversible organic brain syndromes. It also contains a brief discussion of pharmacological issues and a list of psychoactive drugs which may be prescribed for geriatric patients.

The objectives of this module are to:

- Provide information about aging as a normal process;
- Distinguish between normal age-related physiological changes and pathological processes;
- Define and describe the symptoms of organic brain syndrome;
- Distinguish between organic brain syndrome and organic brain disorders;
- Present current research on the structural changes of the brains of Alzheimer's patients;
- Offer information on diagnostic tests and procedures and present diagnostic instruments for assessing dementing illnesses;
- Present current information on pharmacological and other methods of treatment;
- Discuss current policy issues related to Alzheimer's disease and patient care;
- Present information on the problems of caregiving.

The anticipated outcomes of this training are to:

- Increase understanding of an individual's adjustments to age-related physiological changes;
- More accurately assess clients with symptoms of organic brain syndrome;
- Distinguish reversible and irreversible symptoms; better use diagnostic tests and/or measures;
- Appropriately make referrals and work with other professionals;
- Assist families in their caretaking reponsibilities.

The Aging Process

This module begins with definitions of what constitutes aging, and an overview of the biological changes normally associated with the aging process. This background will assist participants to distinguish the normal properties of aging from the disease-related changes thus placing the unit on organic brain disease in its proper perspective.

Definitions

> Aging refers to the regular changes that occur in mature genetically representative organisms living under representative environmental conditions as they advance in chronological age (Birren & Renner, 1977, p. 4).
>
> . . . aging in the total animal may be more than the summation of changes that take place at the cellular, tissue, or organ level. Life of the total animal requires the integrated activity of all the organ systems of the body to meet the stresses of living (Shock, 1977, p. 148).
>
> Growing old is a dynamic process encompassing complex bodily changes, redefinitions of social identities and adjustments in psychological functioning. By itself chronological age has little meaning, although it does serve as a convenient indicator not only of physiological change but of social status as well (Hendricks & Hendricks, 1977, p. 23).
>
> Aging is part of the developmental sequence of the entire life span. Beginning with conception, this developmental sequence includes prenatal growth and development, birth, infancy, childhood, adolescence, young adulthood, middle age and senescence. Aging is a normal part of the total process (Beaver, 1983, p. 2).

The Biological Process of Aging

Aging is most often associated with the biological determinants that gradually alter appearance, physical capacity, and behavior. Most professionals are aware that this is a gross oversimplification. Nonetheless, in practice, it is difficult to distinguish disease-related changes from the normal changes that accompany the aging process (Andres, 1984). Such an assessment is made even more complicated by the fact that the processes of aging vary widely among individuals. Also, an individual's different organ systems may age at differing rates (Brody, 1985; Zarit, 1980).

Despite these complexities, biological researchers have come to some fairly consistent agreement about the decremental changes which they consider to be normal characteristics of aging. Those summarized by Brody (1985, p. 19) include:

> Failing motor ability involving reduced speed and diminished vigor of muscle contraction;

- Deterioration of the nervous system--encompassing a slowing of reflex responses, poorer muscular coordination and failing vision;

- Lessening in the ability of the body to maintain its normal core temperatures;

- Changes in the cardiovascular system, including: (1) diminished capability of the heart rate to compensate in response to stress, (2) decreased efficiency of the heart as a pump, (3) hardening of the arteries, (4) reduction in the elasticity of blood vessel walls, (5) increased peripheral vascular resistance, and (6) increased blood pressure;

- "Irreversible changes" in the respiratory system involving reduced capacity;

- Lowered immunity to infection, making older people more susceptible to viral and bacterial infection (see Kenney, 1982; Rockstein & Sussman, 1979, for further discussion).

Kalish (1982, p. 21-22) suggests that describing the decrements that occur with aging is only the first step in ascertaining their meaning for a particular person. He offers the following series of questions to assist in understanding how an individual has adjusted to age-related change.

1. How does it matter? Granted that we can accurately measure innumerable age-related changes: do these changes necessarily have a meaningful impact on the lives of the persons affected? Substantial hearing loss obviously does; so does severely reduced short-term memory. But how important is reduced olfactory capability? Or sensitivity to temperature change?

2. Does it imply other changes of a more serious nature? A relatively rapid decline in certain types of cognitive capacities may indicate cardiovascular or other health problems, perhaps prognosticating more serious illness or even death. Another change may signify little of importance for an individual's future.

3. Will an intervention alter the path of the decrement? Will a surgical procedure, or any health treatment, serve to ameliorate the problem? Will improved social relationships, the reestablishment of feelings of personal meaningfulness, an increase in sensory or cognitive stimulation, or any other planned intervention make any difference?

4. Is there any mechanical device that can help? Can the problem be helped or corrected by eyeglasses? A hearing aid? An artificial limb?

5. How is the individual coping with the losses, and how can he or she be enabled to cope more effectively?

> Three people suffering the same hearing loss may respond in three different ways: Person A obtains a hearing aid and begins to learn lip reading; he remains reasonably cheerful. Person B refuses a hearing aid and retreats into a solitary life; he becomes depressed. Person C also rejects a hearing aid, but she manages to find a friendship group that will accept her hearing loss and make the important adjustments to her condition themselves.

While the changes discussed here have a major component, it is important to realize that their overall impact on the individual varies with her/her unique life history and personality constellation. For this reason, the fact that aging is a normal biopsychosocial developmental process needs to be emphasized. This framework underscores the fact that while decremental changes do occur more frequently in the aged, they can, and do, occur in younger people as well. It also shows that while significant functions in the older person may show decline, particularly those with a strong biological basis, other functions may show age-related gains. This leaves the door open to see the fact that old age can be a time of growth as well as decline. The human service professional who is open to the view that development/change takes place throughout the life cycle will be better equipped to distinguish between age-related and other changes in the older adult.

The definition of aging encompasses more, however, than those biological changes in the structure and fuctions of body organs and systems that occur over time. It is more accurate to differentiate three kinds of aging: biological aging, referring to an estimate of the individual's present position with respect to his potential life span; psychological aging, including the adaptive capacities of individuals; and sociological aging, involving the roles and social habits of an individual with respect to other members of a society (Birren, 1968, 1969; Birren & Renner, 1980; Greene, 1986; Zarit, 1980). The interaction of these three defines the aging process. Therefore a comprehensive evaluation of the elderly client will include an assessment of the complex interaction among biopsychosocial factors.

Sample Discussion Questions and Issues

- How consistent is each of the definitions of aging with the others?
- Do these definitions agree with the trainees' views and understanding of aging? If so, in what way, and if not, how do they differ?

Suggested Training Activity

Provide half of the trainees with plastic goggles and/or ear plugs to simulate reduced sight and hearing capacities. Ask the other half of the group to work in partnership with a member wearing goggles and/or earplugs and record their behaviors as they attempt to move an object, a chair, or person from one place to another within the room; to distribute books or materials or collect all objects of a specified color and/or shape.

Mental Dysfunctioning in Aging

The purpose of this unit is to distinguish between the classifications of organic brain syndrome and organic mental disorder. The correct use of this nomenclature is important to assessment and treatment, and in working with other health and mental health professionals.

While the vast majority of people over 65 may experience some, all, or none of the normal physiological changes associated with aging and live full, satisfying lives, a number of the elderly develop severely debilitating conditions that result in severe impairments in functioning. Although organic mental disorders can occur in individuals of any age, they are found more often in the elderly. Because of the difficulties in diagnosing, treating, and caring for individuals experiencing organic mental disorders, special attention is focused on them here.

Definitions

Organic mental disorders and organic brain syndromes are both psychological and/or behavioral abnormalities associated with transient or permanent dysfunctions of the brain (Matteson, 1984). In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III), a distinction is made between organic brain syndromes and organic mental disorders in terms of etiology. The term organic brain syndrome is the more global or general of the two and is used to encompass a constellation of psychological and/or behavioral signs and symptoms without reference to etiology. The term organic brain disorder is used when the etiology of the dysfunction is known or presumed. Limitations in our knowledge sometimes make it impossible to determine whether a given disorder in a particular individual should be considered an organic mental disorder, and at this time the diagnosis may be made only on the basis of excluding other possibilities. Dr. Gene Cohen (1980) of the National Institute of Mental Health suggests that the medical evaluation include a thorough general medical work-up in addition to extensive neurological and psychological testing.

The distinctive features of an organic brain syndrome are:

1. **Impairment of memory.** There are three functions involved: initial registration of the stimuli in the mind, retention of the memory that was registered, and ability to recall the memory voluntarily.

2. **Impairment of intellect.** This relates to comprehension, calculation, general fund of information, and ability to learn.

3. **Impairment of judgement.** Comprehension and ability to weigh options and formulate decisions and actions are affected.

4. **Impairment of orientation.** Orientation of time, place, and person depend on attention, perception, and memory capacities. Time is the first sphere to be impaired, place is next, and the identities

of others and of oneself are the last sphere to be affected.

5. **Lability and shallowness of affect.** Excessive emotional responses, blunting of feeling and response, and shallowness and inappropriate affect are demonstrated (Butler & Lewis, 1982, p. 91).

The presence of impairment in these five areas of mental functioning may not all be seen at the same time or to the same degree. They may range in effect from barely perceptible changes to a profound loss of functioning. Human service professionals working with the aged should become comfortable in recognizing and evaluating this syndrome in order to make appropriate interventions.

The two most common forms of dementia are: (a) primary degenerative dementia of the Alzheimer's type (SDAT) related to atrophy of the brain, and (b) multi-infarct dementia associated with damage to the brain due to vascular disease and stroke (Butler & Lewis, 1982; DSM-III, 1980).

Sample Discussion Questions and Issues

Have any trainees had experience in diagnosing dementia that they would be willing to share with the group?

Have any trainees participated in a team approach to diagnosis of mental malfunctioning in the elderly? If so, what unique contributions can be made by human service professionals?

Senile Dementia of the Alzheimer's Type (SDAT)

The purpose of this unit is to point out the unknowns related to the causes of senile dementia of the Alzheimer's type and the controversies surrounding diagnosis. Articles selected for review provide a summary of the state-of-the-art research on the causes and possible cures for SDAT. This section should be updated as new information becomes available.

Human Behavior

"Severe memory loss is never a normal part of growing older" (Mace & Rabins, 1981, p. 7). Rather, senile dementia of the Alzheimer's type (SDAT), the most frequent cause of irreversible dementia in adults, is a disease of unknown cause. Studies suggest that five percent of people over 65 years of age suffer from a severe intellectual impairment with another five percent suffering from milder impairments. While these diseases become more prevalent in people over 80, about 80 percent of those individuals who live into very old age never experience significant memory loss. Slight forgetfulness is common as people age, but usually this does not interfere with their lives (Mace & Rabins, 1981, p. 7).

Because the cause(s) of SDAT are still unknown, there continues to be a lack of consensus about the nature of the disease and the origin of symptoms. "While some scientists think the various symptoms arise from a number of disparate mental and/or physical disorders sharing a common neurological pathway, most appear to believe that single disease entity is responsible for the 'all systems stop' degeneration that characterizes SDAT" (JAMA, 1984, p. 1805).

The relationship between the status of the brain and the clinical manifestations of organic brain syndrome is also a matter of controversy. It is known that the brain cells atrophy and degenerate, most strikingly in the cerebral cortex in an area of the forebrain known as the nucleus basilus. Upon autopsy, the brain of the Alzheimer's patient is found to have structural changes including weight loss, senile plaques, neurofibrillary tangles, and granulovacuolar degeneration of cells (Sapolsy, Krey, & McEwen, 1984; Terry, 1984; Vogel, 1977).

A review of the literature, however, indicates that while the cognitive functions of older adults do depend on the structural and functional status of the brain, there is no consistent pattern (Eisdorfer, 1984; Vogel, 1977). In general there is a poor correlation between the degree of deterioration and neurological changes and the severity of mental symptoms. Persons who have had little neuropathology sometimes showed serious mental and psychiatric change, while others with profound brain damage have had only mild psychiatric disorders (Butler & Lewis, 1982, p. 2). For this reason, it is thought that factors other than anatomical brain changes contribute to mental disorders such as SDAT. Other variables to consider include personality, heredity, environmental stress, and socioeconomic factors.

In the course of evaluation and treatment of a dementing illness, the skills of several highly trained professionals are often needed. The human service practitioner who is knowledgeable about the biopsychosocial aspects of organic brain disorders has much to offer other allied health professionals, and a critical role to play in assisting the aged client and his/her family.

Sample Discussion Questions and Issues

Why has there been an increase in the incidence of senile dementia of the Alzheimer's type? Because people are living longer? Because of new advancements in diagnosis?

Is it possible that in the past older individuals with the same symptoms were diagnosed as psychotic?

If so, what does the refinement in diagnosis mean for treatment?

What types of services are considered when a person is diagnosed as having SDAT?

Research

Rothman (1979) reminds us of the rapidly expanding knowledge base and the absense of opportunity for human service providers to "search the knowledge pool for that which would be useful to them and to make systematic application of what is there" (p. 82). Nowhere is this more true than in research on Alzheimer's disease. Over the last decade, there has been a growing interest among researchers in the "elusive causes of Alzheimer's disease" (Cohen, 1984). These studies have focused on such diverse etiological factors as chemical deficiencies, brain lesions, autoimmune disorders, and genetic abnormalities. While there are some promising leads (Davies, 1984; Luine, 1984; Sapolsy, Krey, & McEwen, 1984), to date the cause(s) of this dreaded disease are still unknown.

"Treating symptoms--there is no therapy for the disease per se--is a task that appears as difficult as diagnosis" (JAMA, 1984, p. 1812). While there appears to be considerable evidence that cholinergic neurotransmission is closely involved in memory processes (Cooper, 1984), drug therapy has not produced significant differences in patient functioning. Because the causes of senile dementia of the Alzheimer's type are not known, and at present there are no courses of treatment available to curtail or reverse its progression, it is especially important for practitioners to keep abreast of current research studies. Such information will allow them to better deal with other professionals and answer clients' questions. The following articles provide a summary of the state-of-the-art on Alzheimer's research:

Cooper, S.J. "Drug Treatments, Neurochemical Change and Human Memory Impairment." In B.A. Wilson and N. Moffat, eds. Clinical Management of Memory Problems. Rockville, Maryland: Aspen Systems Corporation, 1984.

This clear, easy-to-read chapter examines the evidence related to cholinergic neurotransmission thought to be involved in the memory process. It explains why impairments in performance are difficult to measure and provides summaries of research studies using various drug treatments.

Crook, T. "Antidementia Drugs." NCDEU Updates, Vol. 19. Rockville, Maryland: Center for Studies of the Mental Health of the Aging, NIMH, 1983. Reprint from Psychopharmacology Bulletin, 19, 1 (1983), 69-71.

This article presents a brief easy-to-understand update on the antidementia drugs most currently under investigation. Each family of drugs under trial is linked to supporting evidence for its use, depending upon assumed causes for dementia. The author concludes that at the present time "we have no effective pharmacologic treatments for the cognitive symptoms that are at the core of senile dementia."

JAMA. "Attempts to Vanquish Alzheimer's Disease Intensify, Take New Paths." Medical News, 251, 14, (April 13, 1984), 1805-1814.

There is a lack of consensus about the causes of senile dementia of the Alzheimer's type (SDAT), and researchers are now looking at a number of neurochemical changes which are discussed in this article. Most evidence now points to difficulties associated with the neurotransmitter's synethsizing and degrading enzymes, namely choline acetyltransferase and acetylcholinesterase. The article also discusses viral causes, abnormal proteins, and drug therapy.

Larson, E., Reifler, B.V., Canfield, C., and Cohen, G. "Evaluating Elderly Outpatients with Symptoms of Dementia." Hospital and Community Psychiatry, 35 (May 1984), 425-428.

This article refutes the view that if all demented patients receive an extensive work-up many will be found to have curable cognitive impairment(s). In addition, the authors suggest the recommended evaluations are expensive and may be taxing or even harmful for the patient.

Diagnosis

This unit provides a review of the diagnostic tests and procedures used to diagnose dementing illnesses. A discussion of how to distinguish depressive illness from organic mental disorders should also be included.

Method

"Senile dementia is one of the most overdiagnosed and misdiagnosed disorders of the mind" (Cohen, 1980, p. 2). Because of our limited knowledge and lack of clear-cut diagnostic tests, the diagnosis of Alzheimer's disease in the living patient must be formulated solely on the basis of exclusionary criteria. That is, the diagnosis can only be reliably made after all other possible causes of cognitive impairment have been systematically ruled out (NIMH, 1984).

Diagnosis is made even more difficult because of the many other problems and disorders whose symptoms resemble those of SDAT. These include, among other things, general surgery, infections, metabolic disorders, drug side effects (see Appendix A of this module), circulatory problems, brain tumors, toxicity, neurological disorders, e.g., multiple sclerosis, head trauma, and depression (Butler & Lewis, 1982; Cohen, 1980).

Human services professionals in a multidisciplinary diagnostic team need to be familiar with the various evaluation procedures listed below and, where appropriate, be able to administer one of the short portable mental status exams as part of a clinical interview. In general, a good evaluation includes a medical and neurological examination, an evaluation of the person's social support system, and an evaluation of his/her remaining abilities. Mace and Rabins (1981, p. 14) detail the following tests and procedures and indicate what they may reveal:

(1) **Detailed history**--indicates how the person has changed;

(2) **Physical history**--reveals other health problems;

(3) **Neurological examination** -- reveals changes in the functioning of the nerve cells of the brain or spine;

(4) **Laboratory tests**--detect anemia and infection;

(5) **Blood chemistry tests**--indicate liver and kidney problems, diabetes, and vitamin deficiencies;

(6) **Thyroid studies**--reveal thyroid problems (also producers of dementing illness);

(7) **Venereal disease test**--show presence of venereal disease (syphilis used to produce dementing illness before penicillin);

(8) **Lumbar puncture**--rules out infection in the central nervous system;

(9) **Electroencephalograph (EEG)**--records the electrical activity present in the brain and aids in the diagnosis of delirium;

(10) **Computerized axial tomogram (CAT Scan)**--produces a picture of the brain and can find evidence of stroke, multi-infarct dementia tumors, changes in fluids and blood surrounding and/or in the brain;

(11) **Neuropsychological testing** -- determines in which areas of mental functioning the person is impaired;

(12) **Occupational therapy evaluation** -- determines how much the person is able to do for herself and what can be done to help;

(13) **Mental status examination**--determnes the ability to remember, concentrate, do abstract reasoning, do simple calculations and copy designs (see Appendices B and C at the end of this module for examples);

(14) **Psychiatric and psychosocial evaluation** -- provides the basis for the development of a specific plan for the care of the individual.

In addition to the "usual" information obtained in a biopsychosocial evaluation, practitioners in gerontology should be prepared to administer a mental status examination and to differentiate between depressive and dementing illness. The "Mini-Mental State" (Folstein et al., 1975) and the Mental Status Questionnaire (Kahn et al., 1964), practical methods for grading the cognitive state of clients (see Appendices B and C) are most often used as part of the diagnostic process. Appendix D is Patterson's (1977) list of signs which suggest organic mental change and those which may suggest depression.

In setting up a treatment plan the human service practitioner's expertise in obtaining community services and working with family caregivers can be invaluable. Studies have shown that family members caring for Alzheimer's disease patients appear to be subject to severe stresses, and may be at especially high risk for depressive reactions (NIMH, 1984). Practitioners who are prepared to use family and group treatment approaches with caregivers of Alzheimer's disease can help reduce the burden of home care (Kapust, 1982); (see Modules #5 and #8).

Sample Discussion Questions and Issues

What characteristics might a person exhibit that would indicate that mental status tests should be administered?

Would special interviewing techniques need to be employed in conducting any of the mental status examinations?

Suggested Training Activities

Training participants should be given the opportunity to use the mental status examinations (found in Appendices B and C of this module) and learn how to score them. The mental status examination forms and outlines from the Appendices can be reproduced and distributed to trainees who can then administer them to each other in role play. The trainees being tested can be given a handout listing conditions and symptoms that they can project during the test, or they can be asked to write down a description of symptoms they create themselves.

Policy Issues

The purpose of this unit is to outline policy issues and possible strategies to promote research, treatment and services for Alzheimer's patients and their families, and to encourage practitioners in gerontology to develop policy advocacy skills by documenting needs through the compilation of anecdotal case information.

The most pressing current policy issues related to Alzheimer's disease are the financing of care, and whether or not Alzheimer's should be recognized "as distinct from other conditions that create a need for public intervention" (Office of the Assistant Secretary for Planning and Evaluation, Department of HHS, 1985, p. 36). Current policy is reflected in a report to the U.S. Congress from the Department of Health and Human Services which suggests that Alzheimer's patients already receive benefits and service through ongoing programs and that these patients and their families should not be singled out:

> The service and financing programs that have been described [in this report] do not focus on Alzheimer's as distinct from other conditions that create a need for public intervention. . . . Although not triggered by an Alzheimer's diagnosis, the Department [HHS] has many programs that provide assistance to persons with Alzheimer's disease as well as others who are aged and suffer from chronic illness (pp. 36-39).

Given the overwhelming nature of the problems of dementing illness, it may seem as if there is little that the "average practitioner" can do to affect policy in this area. However, this is hardly the case. There is an important role for human service professionals in promoting the development of affordable community-based services for Alzheimer's patients and their families. Gerontology practitioners need to be aware of relevant proposed legislation at the federal, state, and local levels. With the exception of those employed in public agencies where restrictions on political activities exist, human service professionals should be encouraged to write to Congressional and state legislators, and offer input and recommendations as experts in the field of gerontology.

Documenting anecdotal information is one method that is useful to inform policy-makers and program developers about needs. The results of such case documentation "can have important application for a variety of service providers and particular usefulness to such key consumer groups as the Alzheimer's Disease and Related Disorders Association" (NIMH, 1984, p. 11). By providing documentation of the service needs of Alzheimer's patients and their families, lobbying efforts to appropriately recognize and address this crippling disease can be furthered.

Sample Discussion Questions and Issues

Does the designation of Alzheimer's disease as (one more) chronic illness adequately address care and service needs of the elderly?

What are alternative policies and how would they affect the care and treatment of those suffering from Alzheimer's disease?

Whose responsibility is it, and whose responsibility should it be, to: (1) provide care of the elderly who are no longer able to care for themselves, and (2) to pay for the care to meet the needs of the elderly?

How can human service professionals gain "the ear" of legislators and policy-makers?

What point of view do internal agency policies promote vis-a-vis care and services of the elderly and what can a gerontology practitioner working in an agency do to affect agency policy?

How can public awareness and understanding be used to promote policies responsive to the needs of the elderly?

Workshop participants can be asked to describe anecdotal information and to draw up some samples that relate to current policy formation or pending legislation relevant to gerontology.

Summary of Practice Implications

Proper assessment is the first concern of the gerontology worker with a client who exhibits symptoms of organic brain disease. S/he will need to be familiar with the signs of organic brain syndrome and the assessment techniques that distinguish among reversible and irreversible disorders. In addition, s/he will need to work with other allied health practitioners as part of a team.

Because of their understanding of the psychosocial aspects of chronic illness, human service workers can make an important contribution to the care of the client with Alzheimer's disease. Family caregiving to a severely functionally impaired Alzheimer's patient is often a progressive, all-consuming activity. While at first the individual may experience only minor and almost imperceptible symptoms, gradually, s/he evidences more and more behavior problems. This disruption in life style may bring about emotional and/or social problems in the caretakers as well. The practitioner should be prepared to make specific suggestions about how to manage the more common difficulties such as wandering, dressing, bathing, grooming and incontinence (Mace & Rabins, 1981). They also should be prepared to suggest and help caretakers use appropriate long-term care resources.

Suggested Training Activities

Workshop participants can be asked to share their experiences in working with physicians and/or as part of a team.

An opportunity to role-play interacting with a primary care physician can be used to improve communication, interactional, and collaborative skills.

Workshop participants may find it useful to compile a list of basic guidelines for working with persons with dementia.

ANNOTATED BILBLIOGRAPHY

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: APA Press, 1980.

This book, the third and most recent edition of the American Psychiatric Association's official manual of mental disorders, better known as DSM-III, presents a clear well-defined discussion of organic brain disorders. Its easy to follow format makes it an excellent teaching resource for workshop participants who are not up-to-date on this subject. Information on the differential diagnosis of organic brain disorders and depressive disorders is also given.

Brody, E. *Mental and Physical Health Practices of Older People: A Guide for Health Professionals*. New York: Springer Publishing Co., 1985.

This book provides much-needed information about the day-to-day mental and physical health experiences and practices of the elderly. For example, how do the elderly comply or fail to comply with professional recommendations. It begins with an overview and the health situation and needs of older people in the U.S., and describes demographic developments and the present health care system. The second part focuses on a research study and includes a description of the 132 people studied and some basic information about their health, functional capacities, use of health services, and attitudes about health care.

Center for Studies of the Mental Health of the Aging. "Research Update on Alzheimer's Disease - 1984." Rockville, MD: U.S. Department HHS-NIMH, 1984.

This article, available from the NIMH Center on Aging, provides an update on activities and information related to Alzheimer's disease. This includes epidemiologic data, a discussion of the possible causative factors of Alzheimer's disease, the state-of-the-art in diagnosis, treatment and management and the impact of Alzheimer's on the family as caregivers.

Cohen, G. "Fact Sheet: Senile Dementia (Alzheimer's Disease)." Rockville, MD: U.S.Department HEW-NIMH, 1980.

This fact sheet clarifies what senile dementia is and what it is not. It also discusses the symptoms and the clinical course of the disease, the problem of accurate diagnosis, and a comprehensive medical evaluation and treatment.

______. "The Mental Health Professional and the Alzheimer Patient." *Hospital and Community Psychiatry*, 35 (February 1984), 115-122.

The Journal of *Hospital and Community Psychiatry* offers a bi-monthly column of practical information directed to the growing number of mental health professionals who treat the elderly. Dr. Cohen is the column's editor and can be reached at NIMH, 5600 Fishers Lane, Rockville, Maryland 20857. This particular column presents an eight-point treatment intervention management approach that mental health professionals can use with Alzheimer's patients, including diagnosis and differential diagnosis, dealing with the unknowns, treatment of primary symptoms, treatment of concomitant psychiatric symptoms, treatment of concomitant physical illness, attention to environmental stressors, support for the family, and consultation to staff.

Crook, T. "Geriatric Psychopharmacology Update." Rockville, MD: Center for Studies of the Mental Health of the Aging, NIMH, pp. 6-8. Reprinted from Tomorrow's Pharmacist, 4, 1 (January 18, 1982).

This article focuses on the psychotherapeutic drug needs of the elderly and the outlook for the future. It points out some of the adverse effects of certain medications, and discusses the use of antidepressants, "sleep" and antianxiety medications.

Drummond, L., Kirchhoff, L., and Scarbrough, D.R. "A Practical Guide to Reality Orientation: A Treatment Approach for Confusion and Disorientation." The Gerontologist, 18, 6 (1978), 568-573.

This guide provides basic information about the use of reality orientation, particularly with an elderly population. The authors suggest that the concepts can be learned quickly and can be used in any setting with patients having a variety of diagnoses. However, an effective program depends on commitment by all personnel and management support. Consequently, the social worker should spend time on staff acceptance and coordination.

Finkel, S.I., Stein, E., Miller, N., Cameron, I., Hontela, S., and Eisdorfer, C. "Special Perspecitives on Treatment Planning for the Elderly." In American Psychiatric Association, Treatment Planning in Psychiatry, 1982, pp. 379-433.

This book chapter presents an excellent overview of the interrelationships among biological, psychological and social aspects of aging. It is particuarly useful in understanding how psychiatric symptoms can be precipitated by prescribed and unprescribed medications and by medical illness. Case studies illustrate these difficulties and treatment suggestions are made.

Kapust, L.R. "Living with Dementia: The Ongoing Funeral." Social Work in Health Care, 1 (1982), 79-91.

Dementia is an illness which profoundly affects the patient's physical and emotional well-being. The impact of the disease extends far beyond the patient himself, touching each family member involved in the patient's care. Social workers can offer valuable assistance to the family as they experience each stage of the illness. This article makes suggestions in this area and offers several theoretical constructs for understanding the grieving process of the family. Clinical case examples are used to highlight individual and group therapeutic interventions.

Kenney, R.A. Physiology of Aging: A Synopsis. Chicago: Year Book Medical Publishers, Inc., 1982.

This concise text offers a description of the functional changes that occur as a part of the normal course of aging, and distinguishes these normal changes from specific pathologic processes that occur with increasing frequency as an individual ages. It does presume its readers are already familiar with normal physiology. Discussions of general aging processes, theories of aging and a description of aging tissues and organ systems are included.

Mace, N.L., and Rabins, P.V. The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illnesses, and Memory Loss in Later Life. Baltimore: Johns Hopkins University Press, 1981.

While the title would indicate that this book is a family guide, it is much more. It is a must for any professional who wants to understand the problems associated with dementing illness. It can not only help the practitioner better work with the family, but it can assist the professional in interacting with the demented patient.

Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. "Alzheimer's Disease." A Report to Congress from the Department of Health and Human Services. Washington, DC, February 1985.

This recent report presents information on (1) new initiatives regarding Alzheimer's disease; (2) research, education and demonstration efforts; (3) programs serving persons with Alzheimer's disease; and (4) policy issues regarding the financing of care. It is an up-to-date compendium of research, activities, and financing sources. The policy discussion regarding the financing of care raises an important issue for debate--whether Alzheimer's disease should be treated "as distinct from other conditions that create a need for public intervention." The Report suggests that reimbursement for medical and social services are already covered by existing programs such as Medicare, Medicaid, Social Security, social services block grants, etc.

Reisberg et al. "Global Deterioration Scale GDS for Age-Associated Cognitive Decline and Alzheimer's Disease." American Journal Psychiatry 139 (1982), 1136-1139.

This is a new aid to accurate diagnosis as it relates to the stages of Alzehimer's disease. This detailed scale lists seven clinical phases, ranging from phase 1 - normal, to phase 7 - late dementia. Each phase is associated with a Global Deterioration Scale stage of cognitive decline and with clinical characteristics.

Sands, D. and Suzuki, T. "Adult Day Care for Alzheimer's Patients and Their Families." The Gerontologist, 23, 1 (1983), 21-23.

This article reports on the Harbor Area Adult Day Care Center which has operated for two years as a respite service to families caring for a relative with Alzheimer's disease or a related disorder. This article covers the rationale, history, program staffing, funding and general experience of the project during that time.

Terry, R.D. and Wisniewski, H.M. "Structural Aspects of Aging of the Brain." In C. Eisdorfer and R.O. Friedel, eds. *Cognitive and Emotional Disturbance in the Elderly: Clinical Issues*. Chicago: Year Book Medical Publishers, Inc., 1977.

This chapter describes the results of studies designed to evaluate the relationship between organic changes in the brain and altered emotional and cognitive behaviors associated with the aging process. "An important finding resulting from these studies has been that we observe only quantitative, not qualitative, changes in brain structure in the brains of those with senile dementia as compared with those who have aged normally. One cannot help but wonder, then, whether we should consider that a pattern of continuous changes characterizes the passage from normalcy to that dreadful extreme, senile dementia" (p. 3).

Weisberg, J. "Reaching the Mentally-Impaired Elderly and Their Families Through Music: The Account of a Nursing Home Social Worker." *OMEA* (February-March 1985), 17-18.

This is a moving article about an innovative treatment method in which the social worker is able to reach severely mentally-impaired elderly nursing home residents through music. Music is presented as a means of engaging impaired aged either individually or in groups and as a way of working with families who may feel awkward or frustrated visiting their impaired relative.

Whanger, A.D. and Myers, A.C. *Mental Health Assessment and Therapeutic Intervention with Older Adults*. Rockville, MD: Aspen Publication, 1984.

This book provides a series of readings on geriatric mental health care. It includes chapters on the major mental health disorders, both functional and organic, and reflects the up-to-date information of the DSM-III. It also contains a summary of psychoactive drugs for geriatric patients.

Wilson, B.A. and Moffat, N., eds. *Clinical Management of Memory Problems*. Rockville, MD: Aspen Systems Corporation, 1984.

This book includes a series of readings related to memory problems. These include theory assessment, therapy methods, drug treatment, and "management" of the patient.

Zarit, S. *Aging and Mental Disorders*. New York: The Free Press, 1980.

This text presents material on a wide range of topics dealing with the mental health of the aging. This includes chapters on brain disorders and their treatment, sexuality and aging and physical assessment. The chapter on physical assessment is particularly suitable for the social worker who is engaged in making biopsychosocial assessments (and home visits).

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AUDIOVISUAL RESOURCES

Videocassette: Interviewing Impaired Older People
35 min., 1981

(Contact: Audrey McDonald
Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08540

Presents problems that research interviewers encounter and methods used in interviewing the impaired elderly.

Videocassette: Rural America: Coming of Age
30 min., 1981
Penn State Television, producer

This documentary, built upon the agenda for the 1981 White House Conference on Aging, focuses on innovative programs to help the rural elderly with problems in transportation, employment, health, energy, housing and loneliness.

APPENDIX A

Psychopharmacology

"Nonphysician mental health personnel should know what drugs an older person is taking whether for physical or mental conditions" (Butler & Lewis, 1982, p. 360). There are several reasons why this information is needed to properly evaluate and plan treatment for the older adult. Among the many examples, psychiatric symptoms can be precipitated by both unprescribed and prescribed medications (Finkel et al., 1982). Both reversible and irreversible organic brain disorders can occur with use of cortisone series; steroids and affect mood, with manic and depressive manifestations; diuretics may lead to dehydration and mental confusion; while Levodopa (anti-Parkinsonian) and indomethacin (antiarthritic) may cause psychotic behavior (Butler & Lewis, 1982, p. 106).

"The process of aging carries with it certain changes in the way drugs are absorbed, distributed in the body, metabolized and eliminated" (Crook, 1982). Changes in sensitivity to medications as well as an increased risk of adverse effects for the many aged patients who require multiple drugs for medical as well as psychiatric disorders also complicate the picture. While judicious use of many drugs offers dramatic benefits to many aged patients, much still needs to be learned about the effects of specific medications on the older patient. The human service worker can play an important role along with other health professionals in identifying probable side effects and making the necessary referrals.

The following Summary of Psychoactive Drugs for Geriatric Patients (Whanger, 1984) is intended to assist practitioners in becoming more familiar with the drugs most frequently used by older patients. The Physicians Desk Reference is another source of information about the side effects and complications of all drugs.

Summary of Psychoactive Drugs for Geriatric Patients

The drug lists provided below are not exhaustive but rather reflect clinical usage and experience. The drugs are listed in general descending order of frequency of the author's use of them in older patients. The dose range is in broad terms only, and cannot completely reflect the wide physiologic range of need and tolerance in the elderly. The doses are in milligrams per day unless noted otherwise. They reflect the total daily dose and not the actual frequency or individual dosages. The best general dose rule is to "start low and go slow." Only the more common side effects are noted.

Generic Name	Trade Name	Dose Range	Side Effects
Major Tranquilizers			
1. Haloperidol	Haldol	0.2-10	Hypotension,
2. Thiothixene	Navane	0.3-10	drowsiness,
3. Perphenazine	Trilafon	2-12	extrapyramidal symptoms,
4. Thioridazine	Mellaril	10-300	EKG changes,
5. Trifluoperazine	Stelazine	1-10	tardive

6. Fluphenazine	Prolixin Decanoate (IM) Prolixin Enanthate (IM)	6.25-25 every 3/wks. 6.25-25 every 2/wks.	Dyskinesia, anticholinergic effects, rigidity; can potentiate other drugs
7. Chlorprothixene	Taractan	25-200	
8. Fluphenazine	Prolixin (oral)	1-5	
9. Prochlorperazine	Compazine	5-20	
10. Chlorpromazine	Thorazine	10-300	
11. Molindone	Moban	10-50	

Minor Tranquilizers

1. Lorazepam	Ativan	0.5-6	Drowsiness, ataxia, confusion, habituation; can potentiate other drugs
2. Oxazepam	Serax	10-60	
3. Alprazolam	Xanax	0.25-1.5	
4. Diazepam	Valium	2-20	
5. Chlordiazepoxide	Librium	5-30	
6. Meprobamate	Equanil, Miltown	200-1,200	

Sedative Antihistamines

1. Diphenhydramine	Benadryl	12.5-50	Drowsiness, dizziness, anticholinergic effects
2. Hydroxyzine	Atarax, Vistaril	20-100	
3. Promethazine	Phenergan	12.5-50	

Antidepressants--Tricyclic and Others

1. Doxepin	Sinequan, Adapin	30-150	Drowsiness, hypotension, blurred vision, dry mouth, constipation, anticholinergic effects, hypertension, confusion
2. Imipramine	Tofranil	30-150	
3. Trazodone	Desyrel	50-300	
4. Amoxapine	Asendin	25-150	
5. Maprotiline	Ludiomil	25-75	
6. Nortriptyline	Pamelor, Aventyl	30-150	
7. Desipramine	Norpramin, Pertofrane	25-100	
8. Amitriptyline	Elavil	30-150	

Antidepressants--MAO Inhibitors

1. Phenelzine	Nardil	15-60	Hypotension, hypertensive crises, interactions
2. Tranylcypromine	Parnate	10-30	

Stimulants

1. Methylphenidate	Ritalin	5-15	Agitation, CV stimulation, habituation
2. Dextroamphetamine	Dexedrine	2.5-10	

Antimanic Drugs

1. Lithium carbonate	Lithonate, Eskalith	150-900	Tremor, ataxia, confusion

Hypnotics			
1. Chloral hydrate	Noctec	0.5-1.5 g.	Gastritis, dizziness, hangover, habituation
2. Temazepam	Restoril	15-30	
3. Flurazepam	Dalmane	15-30	
Vasodilators			
1. Cyclandelate	Cyclospasmol	400-800	Flushing, weakness
2. Isoxsuprine	Vasodilan	30-60	
Antiparkinson Agents			
1. Diphenhydramine	Benadryl	12.5-50	Anticholinergic effects, confusion, urinary retention, depression
2. Trihexyphenidyl	Artane	1-6	
3. Benztropine	Cogentin	0.5-2	
4. Amantadine	Symmetrel	100-300	
Miscellaneous Drugs			
1. Ergot Alkaloids, hydrogenated	Hydergine	1-3	Mild agitation, nausea

* * * * *

Source: Whanger, A.D. and Myers, A.C. Mental Health Assessment and Therapeutic Intervention with Older Adults. Rockville, MD: Aspen Systems Corporation, 1984, p. 289.

APPENDIX B

"Mini-Mental State"

Maximum score	Score	
		Orientation
5	( )	What is the (year) (date) (day) (month)?
5	( )	Where are we (state) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record. ___ Trials
		Attention and Calculation
5	( )	Serial 7s. 1 point for each word correct. Stop after 5 answers. Alternatively spell "world" backwards.
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct.
		Language
9	( )	Name a pencil and watch (2 points). Repeat the following "No ifs, ands or buts" (1 point). Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor" (3 points). Read and obey the following: Close your eyes (1 point) Write a sentence (1 point) Copy design (1 point)
	___	**TOTAL SCORE**

Assess level of consciousness along a continuum

Alert Drowsy Stupor Coma

* * * * *

From Folstein, M.F., Folstein, S.E., and McHugh, P.R. "Mini-Mental State," a practical method for grading the cognitive state of patients for the clinician, Journal of Psychiatric Research 12:189-198, 1975, Pergamon Press, Ltd.

Instructions for Administration of "Mini-Mental State" Examination

Orientation

1. Ask for the date. Then ask specifically for parts omitted, e.g., "Can you also tell me what season it is?" One point for each correct.

2. Ask in turn "Can you tell me the name of this hospital?" (town, county, etc.). One point for each correct.

Registration

Ask the patient if you may test his memory. Then say the names of 3 unrelated objects, clearly and slowly, about 1 second for each. After you have said all 3, ask him to repeat them. This first repetition determines his score (0-3) but keep saying them until he can repeat all 3, up to 6 trials. If he does not eventually learn all 3, recall cannot be meaningfully tested.

Attention and calculation

Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.

If the patient cannot or will not perform this task, ask him to spell the word "world" backwards. The score is the number of letters in correct order, e.g., dlrow = 5, dlorw = 3.

Recall

Ask the patient if he can recall the 3 words you previously asked him to remember. Score 0-3.

Language

Naming: Show the patient a wrist watch and ask him what it is. Repeat for pencil. Score 0-2.

Repetition: Ask the patient to repeat the sentence after you. Allow only one trial. Score 0 or 1.

3-stage command: Give the patient a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.

Reading: On a blank piece of paper print the sentence "Close your eyes," in letters large enough for the patient to see clearly. Ask him to read it and do what it says. Score 1 point only if he actually closes his eyes.

Writing: Give the patient a blank piece of paper and ask him to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously. It must contain a subject and a verb and be sensible. Correct grammar and punctuation are not necessary.

Copying: On a clean piece of paper, draw intersecting pentagons, each side about 1 inch, and ask him to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

Estimate the patient's level of sensorium along a continuum, from alert on the left to coma on the right.

APPENDIX C

Mental Status Questionnaire--"Special Ten"

1. Where are we now?
2. Where is this place (located)?
3. What is today's date--day of month?
4. What month is it?
5. What year is it?
6. How old are you?
7. When is your birthday?
8. What year were you born?
9. Who is President of the United States?
10. Who was President before him?

* * * * *

Questions 1 and 2 refer to place.

Questions 3, 4, and 5 refer to time.

Questions 6 and 7 refer to memory recent or remote.

Question 8 refers to memory remote.

Questions 9 and 10 refer to information memory.

APPENDIX D

Signs of Organic Mental Change and Depression

When a patient is suspected of having organic deterioration, the examiner must force himself to become rigorous and to list just what signs suggest organic mental change. For example:

- Did he say his memory is failing or that he cannot think as clearly or as fast as he used to?
- Did his memory fail in specific instances?
- Was his thinking less clear and less quick than would be expected for a person with his experience?
- Did he fail to understand instructions?
- Did his mood change quickly and unpredictably? For example, did he cry without feeling sad?

Each of these points can be good evidence for organic deterioration. If the patient has some of these signs, an organic brain syndrome may be present. Then a differentiation from depression must be made. Some points to consider are the following:

- Did he think he was depressed and did he seem sad when he talked?
- Did he have a sense of helplessness and hopelessness?
- Did he insist that he is ill or deficient or defective without evidence?
- Was there a current cause for him to be depressed?
- Was he slowed up in all of his mental and physical functions as a result of the depression? This slowing up might, at first, be mistaken as evidence for organic deterioration.

* * * * *

Patterson (1977), p. 134-135.

MULTIFACETED GERONTOLOGICAL ASSESSMENT: LEARNING TO EVALUATE THE ELDERLY CLIENT'S FUNCTIONAL CAPACITIES

The purpose of this module is to define multifaceted assessment as a holistic method of evaluating the elderly client's functional capacity. The use of biopsychosocial information to develop an interventive strategy or treatment plan is described.

The objectives of this module are to:

Describe assessment as a process in which social, psychological, and biological factors affecting functional capacity are evaluated;

Explain the benefits of a multidisciplinary assessment team and the skills needed for assessment when done by one practitioner;

Outline the benefits and drawbacks of different assessment instruments;

Describe the uses of multidimensional measures and present them for review.

The anticipated outcomes of this training module are to:

Assess the client's presenting symptoms or complaints;

Use assessment instruments and, where desired, integrate them into the client-worker interview.

The Multifaceted Assessment Process

The purpose of this unit is to introduce multifaceted gerontological assessment as a problem-solving process involving the integration of biopsychosocial variables.

Definitions

The following definitions are provided to facilitate trainees' understanding of assessment.

> Assessment is a social work procedure used for examining the client's problem for the purposes of selecting interventions or treatment modalities. Any assessment aims to identify and explain the nature of a problem, to appraise it within a framework of specific elements, and to use that appraisal as a guide to action (Greene, 1984-86; Perlman, 1957).
>
> The mental health evaluation in its simplest sense is a method of looking at the problems of older people, arriving at decisions that are as accurate as possible as to what is wrong, and concluding what can be done to try to alleviate or eliminate these problems. . . . A gathering together and assessment of the many factors that affect the emotional life of an older person is the process by which such evaluation is carried out (Butler & Lewis, 1982, p. 196).
>
> A decision-making model must begin with a definition of the problem. Assessment is the first stage in the development of a treatment plan. . . . Assessment is a way of systematically gathering information that clarifies and specifies what needs to be done, who should do what, and how to know when it's done (Eyde & Rich, 1983, p. 59).
>
> The clinician needs practical tools that will permit evaluation of individuals' status, prediction of their future course, and planning for their care. In a way, measurements are organizers, capable of turning amorphous and expansive goals into a series of defined tasks (Kane & Kane, 1981, pp. 1-2).
>
> The concept of continuum of care has emerged in response to the evident need for a model that would integrate different levels of distress and provision of services. . . . Basic to the provision of care along the continuum is a clear statement of need. Old age in itself is not a need. Needs are determined by the complex interaction of biological, psychological and social variables. . . . The sum total of the biological, psychological, and social person with an individual history defines the need and subsequently the level of care along the continuum (Eyde & Rich, 1983, pp. 34-38).

One of the primary concerns of the practitioner in gerontology is the matching of differential needs with differential levels and types of service. This is accomplished through the process of multifaceted assessment. A comprehensive assessment of the older adult involves an evaluation of the social, psychological/mental and physical/biological factors that affect functional capacity. The goal is to uncover and integrate those underlying factors to which variations in the client's function or capacity can be attributed.

The Use of the Practitioner in the Interview Process

Engaging an older person in the interview is the first step in assessment. Needless to say, this is facilitated by the practitioner's ability to impart warmth, acceptance, and empathetic understanding. It is also enhanced by the professional's capacity to adapt the interviewing process to the needs of the particular client. Most older persons are perfectly capable of speaking for themselves, especially when the practitioner makes allowances, where need be, for the client's specific limitations and/or disabilities. Loss of hearing and/or vision, limitations in language or mobility, or problems with balance, pain, fatigue, emotionality and mentation all may adversely affect the interview if adjustments are not made (Bloom, 1971; Schmidt, 1975). In general, interviewing should maximize data collection and minimize stress.

Interviewing is an interactional process. The information that clients provide and the way they present themselves can be directly influenced by the conduct of the practitioner in interaction with the client during the interview. Facial expressions, eye contact, body posture, physical positioning, movement and gestures communicate to the client the attitude, receptivity, interest and empathy of the worker. This can determine the level of comfort or discomfort a client feels and thus whether or not complete, accurate information is provided by the client during an interview.

When interviewing a hearing- or sight-impaired person, the worker needs to be in a position where the client can hear and/or see, and be seen and heard by the worker. Physical setting can also impact on the structure of the interview. Touching, an important part of non-verbal communication, may be particularly significant for an older client who may be physically and socially isolated. If, what kind and how much touching is appropriate to each situation must be assessed by the practitioner.

Assessment procedures are also affected by the setting in which they take place and by the cognitive and physical status of the client. An evaluation conducted in a nursing home or hospital environment will be different from that conducted in the client's own home. Nor will an interview with a confused disoriented client yield the same type of information as that with a well-oriented individual. Careful consideration should be given, however, in seeking information from sources other than the client and possibly breaching confidentiality.

Now that the stage is set, the type and order of questions, and the way they are asked by the worker, directly determine what and how much information is forthcoming from the client. In situations where questions need to be read aloud by the worker from a form, this should only be done after the worker has established some rapport with the client, and has provided the client with specific information as to why it is necessary to ask these specific questions in this particular way. General questions should be asked first and the responses should guide subsequent questions to elicit more specific information. The goal of an assessment interview is to obtain information about the following:

- A complete description of the presenting problem
    - When it began
    - The circumstances immediately before and around the time the problem began
    - What efforts have been made to cope with the problem
    - What other things the problem has affected
    - Other problems that have developed
- Current functioning
    - Living arrangement
    - Physical functioning
    - Mobility
    - Self and household care
    - Family relationships
    - Social and community support networks: friends, neighbors, religious activities
    - Health; diagnosed conditions; medications being taken; symptoms not being treated
    - Sleeping pattern
    - Eating habits and nutrition
    - Income
    - Employment
    - Volunteer and community activity
    - Social activities
- Past history
    - Marriage, family, children
    - Employment
    - Family of origin
    - Social and community activities
    - Health

A good way to elicit information on current functioning is to ask a person to describe what their day is like rather than ask specific questions on each subject. While clients are providing information about their problems and themselves, practitioners have the opportunity to observe a client's non-verbal communication and behavior as well as listen to what is being said.

It is important for the interviewer to tell the client the purpose of the interview, why specific information in certain areas is necessary, the next steps in the assessment process, and what services may result from the assessment procedure. Also, confidentiality needs to be addressed both from the perspective of the client's rights to determine who has access to what information, and the situations, if any, in which confidentiality may be limited.

Sample Discussion Questions and Issues

The case can be edited to delete the last paragraph, and provided as a handout to trainees for discussion.

What are the key symptoms of the client's problems?

What additional types of information would trainees want to know and how would they go about obtaining it?

What does the history of the problem suggest in terms of causation?

Trainees can be asked to formulate tentative diagnosis and treatment plan.

How might the concerns of the resident manager of the apartment building be addressed?

Trainees can also be asked to bring in their own case material and to present a case for discussion.

Suggested Training Activities

Case Example

The following case can be used by trainers to illustrate the complex interaction among nutritional, pharmacological, financial and social factors underlying behavioral problems:

> Mrs. R., the resident manager of a low-income housing project for the elderly, called the intake worker at a community mental health center. She requested help in getting Miss L., "a mentally deranged 90-year-old woman" out of the project and into a nursing home. Mrs. R. explained that Miss L. often sat around the lobby with a dazed look. That morning, Miss L. had left a pot on the stove too long, and "had almost burnt down the building." The manager stressed that Miss L. no longer belonged in her own apartment as "she was not able to care for herself."

The caseworker, who was able to arrange with Miss L. for a number of home visits, put together the following diagnostic information: Miss L. had lived in the building for over 10 years, and it was only in the last six months that there had been any difficulties. At that time, there had been a "large" increase in rent, and Miss L. "cut back on her expenses by eating day-old doughnuts on sale at a nearby bakery." Until that time, she usually read the daily paper, paid her own bills, and generally took care of her own affiars. Miss L. said she was annoyed with herself lately as she was always dozing off in the lobby. She also noticed that she was constantly thirsty and urinated frequently. The caseworker observed that Miss L. spoke with flat affect and described her situation as "hopeless."

The caseworker was concerned with the physical changes experienced by Miss L., and decided to encourage her to see a doctor at the local medical clinic. During the medical exam, laboratory tests indicated that Miss L. had diabetes which quickly responded to a change in diet and proper medication. Miss L.'s mental functioning also dramatically improved.

The case can be edited to delete the last paragraph, and provided as a handout to trainees for discussion.

What are the key symptoms of the client's problems?

What additional types of information would trainees want to know and how would they go about obtaining it?

What does the history of the problem suggest in terms of causation?

Trainees can be asked to formulate tentative diagnosis and treatment plan.

How might the concerns of the resident manager of the apartment building be addressed?

Trainees can also be asked to bring in their own case material and to present a case for discussion.

Assessment Instruments

The purpose of this unit is to describe some of the benefits and limitations of assessment instruments and to prepare human service workers to use them in the assessment process when appropriate.

Direct service practitioners often tend to place a high value on the use of multifaceted assessment instruments. "Once a scale is created to measure a complex and abstract quality (for example, socialization patterns, authoritarianism, perceptions of control over one's life, future orientation), some practitioners tend to reify the scores" (Kane & Kane, 1981, p. 12). While the purpose of this module is to assist practitioners in gerontology to become familiar with and use measurement tests, it is important that they do not "overinterpret or misinterpret results" (ibid.) and are able to understand both their limitations and their benefits.

Steinberg and Carter (1983) raise an important question regarding the usefulness of a measurement test in assessing the "whole person":

> Many case-management programs claim to bring to the traditional service network a holistic approach, which is symbolized by a comprehensive and standardized assessment instrument. But the whole-person commitment must be reflected in all the tasks at the client and organizational levels. The whole-person concept... is a philosophical viewpoint with an integrated medical-social stance. Its implementation may be incremental, and diagnostic comprehensiveness may be achieved in cumulative phases. The search for the ideal instrument to assess the whole person must include consideration of program goals, staffing patterns, target populations, capacities to formulate and implement case plans, and evaluation needs.

The acceptability of an assessment instrument is related to the purpose it is intended to serve. The program planner's needs are not the same as those of an administrator or a practitioner. The practitioner, who is concerned with time, analysis, interpretation and ease of administration, uses a measurement instrument to assist in the development of a service strategy or treatment plan; the program planner, who is interested in a systematic and accurate method of data collection, employs assessment tools in the development and design of programs. In selecting an assessment design, the following questions deserve consideration:

> To what degree is the assessment primarily for clinical purposes, administrative purposes or research purposes? What will be the assessment pace (mini-, incremental, immediate, comprehensive) and which assessment instrument, if any, will be used (scope, standardization, uses of summary classification)? What variables from the assessment need to be logged into a client-tracking or management information system?
>
> Which personnel will conduct assessments of clients? The common variations are: (1) case manager alone, (2) case manager with assistance as needed from specialist, and (3) multidisciplinary assessment team. The degree to which assessment is viewed as a

> sensitive clinically-oriented diagnostic process will affect decisions regarding the professional qualifications of the case manager.
>
> If assessments are to be conducted by an individual staff member, to what extent will there be case reviews by supervisors or consultants to ensure completeness and accuracy and to discuss implications of the assessment for case planning?
>
> What policy and procedures will be established to obtain and use assessment information from sources in addition to clients? What formal provisions will be made to protect client rights?
>
> What provision will be made to evaluate the assessment process over time and, if necessary, modify the design to improve its utility? (Steinberg & Carter, 1983, p. 17).

The most desirable assessment tools, obviously, are those that have been found valid (referring to the ability of a measure to reflect the characteristics it is intended to assess) and reliable (referring to the ability, in the absence of changes, to obtain the same results with repeated measures) through research.

Sample Discussion Questions and Issues

Examples of such multifaceted assessment instruments which could be discussed with workshop participants are the Mental Status Questionnaire and the Katz Index of Activities of Daily Living (found in Appendices A and B to this module). Other such multifaceted assessment instruments that could be used are:

Fillenbaum, G.G., and Smyer, M. "The Development, Validity, and Reliability of the OARS Multidimensional Functional Assessment Questionnaire." Journal of Gerontology, 36, 4 (1981), 428-434.

Developed initially in response to a request by the Administration on Aging to examine alternatives to institutionalization, the OARS permits both an overall assessment of individual functioning and a comprehensive assessment of services utilized. This report outlines the development validity, and reliability of Part A of the Questionnaire which permits assessment of an individual's social, economic, mental health, physical health and self-care capacity.

Lawton, M.P., Moss, M., Fulcomer, M., and Kleban, M.H. "A Research and Service-Oriented Multilevel Assessment Instrument." Journal of Gerontology, 37, 1 (1982), 91-99.

This report describes the Philadelphia Geriatric Center Multilevel Assessment Instrument (MAI), an assessment approach built on a conceptual model of the well-being of older people, and designed explicitly to deal with some deficiencies and gaps in existing assessment systems. It evaluates behavioral competence in the domains of health, activities of daily living, cognition, time use, and social interaction. The researchers used the criterion group approach to validation. Correlations between the MAI scales and ratings made by a clinical psychologist and a housing administrator were also involved. The authors conclude with a word of caution about the training of those using the measurement test.

Assessment Methods

Human service workers often associate multifaceted assessments with structured interview forms and sometimes consider their use to fall within the role of other professionals or disciplines. The purpose of this section is to clarify that such assessments are within the practitioner's purview and may be accomplished through alternative methods.

A multidimensional assessment can be carried out through a team approach or by a single practitioner who may include the use of a structured questionnaire in the client interview.

"Team measurement represents the Cadillac of professional assessment" (Kane & Kane, 1981, p. 212). Ideally, it allows each client to be seen by a number of professionals (nurse, social worker, occupational therapist, nutritionist), each representing his/her own field of competence. In this way, they may each make systematic observations and recommendations. Traditionally, social workers have dealt with the client's social situation, physical environment, family relationships, and financial concerns.

More and more human service workers, however, are working in settings where they are called upon to do their own assessment. The practitioner in gerontology, no matter what his/her setting, must first be thoroughly conversant with the holistic assessment procedures that have long been the trademark of the social work profession. Such an assessment or dynamic diagnosis is "a king of cross-sectional view of the forces interacting in the client's problem situation." It is a means of gathering data in order "to establish what the trouble is, what psychological, physical or social factors contribute to it. . . how this affects the client's well-being, what solutions are to be sought, and what exists within the client and in the way of resources and services which may ameliorate the problem" (Perlman, 1957, p. 171).

In addition to being well-versed in interviewing methods, the practitioner doing multifaceted assessment must make a special effort to become more knowledgeable in areas not always associated with human services (e.g., physical disability and use of medications, see Module #1). "Recommendations for specialized assessments could certainly follow from multidimensional measures made by a single interviewer. Clients who need an evaluation by a particular expert (such as dentist, a hearing specialist, a psychiatrist, a prosthetist or a dietician) should be identified from their initial assessment" (Kane & Kane, 1981, p. 212).

An approach to the assessment of the older client which centers around the problem-oriented interview is not the same as an evaluation which focuses on the use of an assessment instrument. In order to understand the relationship between multidimensional assessment and the provision of services to the older adult, it is important to first review the history of measuring health status in terms of function.

Early measurement efforts usually centered around evaluating a single trait or behavior such as muscle power or intelligence. However, the need for a more complete picture of the older adult gradually led to the development of instruments which could evaluate one particular area of functioning or domain. For example, a growing interest in chronic disease and community-based long-term care highlighted the need for measures which could assess activities of daily living; while an increased sensitivity to the differential diagnosis of organic brain disease led to the development of tests which could better identify impairments in cognitive abilities. The result has been a wide array of tests that measure physical, mental and/or social functioning. Many of these unidimensional tests, such as the Katz et al. (1963) Index of Activities of Daily Living (Appendix A) and the Kahn, Goldfarb and Pollack (1964) Mental Status Questionnaire (Appendix B) have been widely accepted and are still in use.

The Katz Index of Activities of Daily Living (ADL) is considered one of the best-known and most carefully studied ADL tests. The measure calls for a rating of six functions in order of decreasing dependency, to determine what assistance, if any, is needed: bathing, dressing, going to the toilet, transfer, continence, and feeding (Kane & Kane, 1981, p. 45). The Mental Status Questionnaire (MSQ) of Kahn et al. (1964) is probably the most widely used test of the cognitive impairments associated with organic brain syndrome. The MSQ consists of ten items related to orientation and memory, and is easily and quickly administered (Butler & Lewis, 1982; Gurland, 1980). Also valuable in the assessment of cognitive abilities is the Folstein-Folstein-McHugh Mini Mental State. While it takes longer to administer than the MSQ, in addition to memory and orientation, it measures registration, attention and calculation and language ability (Butler & Lewis, 1982).

While unidimensional measures may provide helpful assessment information about the older adult, the need to have a holistic picture of the functioning of the elderly client gave impetus to the development of multidimensional measures. Multidimensional assessment procedures are those that combine within a single instrument the major domains of a comprehensive evaluation. They may be viewed as aggregate measures that provide an overview of client status. Some yield a single functional-status score, whereas others provide a distinct score on each separate but related dimension of functioning.

> Multidimensional measures serve several purposes. The clinician needs information about functioning across a variety of domains in order to construct a "snapshot" of the individual's current status. Similarly, a program evaluator who wishes to examine the effects of long-term care service on more than one functional domain also requires a multidimensional measure. Some multidimensional measures. . . synthesize the information into one or more summary statements about the client's status. Such summaries enable one to compare individuals and groups. Theoretically, such comparisons permit more rational allocation of services. Summary scores [also] facilitate equitably applied eligibility criteria for program benefits (Kane & Kane, 1981, p. 209).

Perhaps the most widely-known multifaceted assessment instrument is the OARS (Older Americans' Resources and Services) Multidimensional Functional Assessment Questionnaire, 1978. It was initially developed at Duke University, Center for the Study of Aging and Human Development in response to a request by the Administration on Aging to examine alternatives to institutionalization. Since 1972, it has continued to be part of the initial evaluation of patients in the OARS Geriatric Evaluation and Treatment Clinic. It is also in use in over 100 settings for an increasing diversity of purposes including clinical assessment, population surveys, program evaluation, personnel training, and service planning (Fillenbaum & Smyer, 1981).

The OARS questionnaire (MFAQ) consists of two parts, each of which can be used independently: Part A is functional assessment and Part B, services assessment. The questionnaire, which takes an hour to administer, yields information about functional activity in five domains: (1) social resources, dealing with the quantity, quality and availability of family and friends; (2) economic resources, referring to adequacy of income and resources; (3) mental health, referring to psychiatric well-being and presence of organicity; (4) physical health, encompassing participation in physical activities and the presence or absence of disease; (5) activities of daily living (ADL), including the ability to perform instrumental and physical tasks that allow individuals to live independently (Kane & Kane, 1981, p. 224). Finally, it should be stated that while standardized assessment guides may be a useful and important adjunct to the evaluation process by assuring the coverage of relevant topics and organizing the answers so that they may be readily accessed, they cannot take the place of the highly trained professional (Steinberg & Carter, 1983).

Sample Discussions Questions and Issues

Participants can be asked to relate if and how assessment instruments are used in their practice setting and if they have had any experience using them. (This will allow trainers to determine the amount of time that should be allocated for familiarization with the assessment instruments).

How is it decided in what situations a one-dimensional assessment is adequate, and when and where a more extensive assessment including the use of assessment instruments (and which one[s]) is called for.

Suggested Training Activities

Copies of instruments that are relevant to the practice of the trainee population should be provided and participants be given the opportunity to learn how to administer them. Two instruments are provided in the Apendices to this module. The 105-question OARS form and instructions on how to administer it are available from the Older American's Resource and Services Program of the Duke University, Center for the Study of Aging and Human Development, Durham, North Carolina 27710.

Also available is a streamlined approach to OARS, Pfeiffer's Functional Assessment Inventory. This thirty-minute version contains the same key components and has been well-received. Information about training for the abbreviated OARS is available from Dr. Eric Pfeiffer, Division of Geriatric Psychiatry, 12901 North 30th Street, Tampa, Florida 33612.

Summary of Practice Implications

Multifaceted assessment can serve several important purposes in the diagnostic process. Perhaps its primary function is to help evaluate the client's presenting symptom(s) or complaint(s). Because some older adults may suffer from the effects of multiple chronic ailments as well as numerous psychosocial stresses, such assessment is a way for the practitioner to better understand the complex interaction of physical and mental health factors.

Multifaceted assessment is also used to determine eligibility for service and for program/service accountability. In times of budget constraints, this may raise several policy issues regarding care with some "needy clients falling through the cracks." In addition, assessment is important in research related to the conditions associated with aging. While the human service worker is not often directly involved in research, reading the gerontological research literature can suggest clinical strategies. There is the drawback, however, that many assessment instruments may not be useful in measuring important human characteristics. For these reasons, a give and take between the clinician and researcher is important.

Practitioners need to become acquainted with the most useful assessment instruments, and how to integrate test questions into the unstructured interview in a natural or comfortable manner. Therefore, it is important that participants be provided with an opportunity to have a "hands-on" experience with several of the assessment instruments presented in the Appendices.

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Berkman, L.F. "The Assessment of Social Networks and Social Support in the Elderly." Journal of the American Geriatric Society, 31, 12 (1983), 143-749.

The aim of this paper, which is one of a series of resulting from a National Institute on Aging Conference on Assessment, is to provide the reader with information on the relationship between social support in the elderly and physical health. The author offers epidemiologic work in this area which suggests that there is a relationship between social disconnection and increased mortality even when data are controlled for baseline physical health status, social class, practices such as cigarette smoking and alcohol consumption, physical activity, obesity, and certain eating and sleeping patterns.

Butler, R.N., and Lewis, M. Aging and Mental Health. St. Louis, MO: C.V. Mosby Press, 1982.

This comprehensive and readable book has an excellent chapter on diagnostic evaluation. Specifics are given on what is involved in gathering information on basic medical, psychiatric/mental status and personal data of the older client. A psychiatric checklist, mental status exams, and personal data forms are provided as are interesting suggestions for the use of the mirror and self-drawings in diagnosis.

Eisdorfer, C., and Friedel, R.O., eds. Cognitive and Emotional Disturbances in the Elderly. Chicago: Year Book Medical Publishers, Inc., 1977.

As the title indicates, the focus of this volume is on cognitive disturbance in the aged. The first section deals with basic issues in age-related cognitive disorders, including recent studies in neuropathology, epidemiology, and on the role of stress. This is followed by articles on evaluation of patients in and out of the institution from a medical as well as psychological perspective. The final section is devoted to treatment.

Granick, S. "Psychologic Assessment Technology for Geriatric Practice." Journal of the American Geriatric Society, 31, 12 (1983), 128-742.

This article which discusses the need for psychologic assessment in medical practice is one of a series resulting from a National Institute on Aging Conference on Assessment. The author discusses the relative benefits of tests which evaluate cognitive functioning, visual-motor coordination and spatial perception, personality characteristics and mental health status, and perception of and attitudes toward physical health status. Projective tests and multidimensional measures are also discussed.

Gurland, B.J. "The Assessment of the Mental Health Status of Older Adults." In J.E. Birren and R.B. Sloane, eds. Handbook of Mental Health and Aging. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

This article provides a comprehensive discussion of the purposes and processes of mental health assessment of the older person. Consideration is given to issues of cognitive impairment, depression, dependence, disruptive, bizarre and dangerous behaviors, somatic and sexual symptoms, testing and instruments.

Habot, B., and Lebow, L.S. "The Interrelationship of Mental and Physical Status and Its Assessment in the Older Adult: Mind-Body Interaction." In J.E. Birren and R.B. Sloane, eds. Handbook of Mental Health and Aging. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Mental change is one of the most common components of the stereotype of being "old." This article explores the complex relationship between bodily illness that may occur at any age, "but which when occurring in the elderly produce mental deterioration" and those mental changes which may lead to physical decline. The authors present a wide range of information related to this topic including a discussion of evaluation/examination, medications, metabolic disturbances and depression.

Kane R.L., and Kane, R.A. Assessing the Elderly: A Practical Guide to Management. Lexington, MA: D.C. Heath, 1981.

In this book the authors focus on the specific areas of measurement most important to long-term care. They provide detailed criteria for selecting instruments for specific users, purposes, and client populations, and offer guidelines for evaluating reliability and validity. Measures of physical, mental and social functions are presented as well as multidimensional instruments such as OARS and CARE (Comprehensive Assessment and Referral Evaluation). Suggestions are also made for choosing and using measurements in geriatrics.

Katz, S. "Assessing Self-Maintenance: Activities of Daily Living Mobility, and Instrumental Activities of Daily Living." Journal of the American Geriatric Society, 31, 12 (1983), 721-772.

This article is one of a series to report on the National Institute on Aging Conference on Assessment. The author focuses on elderly persons with disabilities and their need to have help with daily functions such as bathing, dressing and walking, and how this relates to long-term care services.

Rubenstein, L. "The Clinical Effectiveness of Multidimensional Geriatric Assessment." Journal of the American Geriatric Society, 31, 12 (1983), 758-762.

Geriatric assessment has several major purposes including screening for treatable disease, accurate diagnosis, rational therapeutic planning, assuring appropriate use of services, determining optimal placement and documenting change over time. This article, one of a series from a National Institute on Aging Conference on Assessment, examines the effectiveness of geriatric assessment programs.

Rubenstein, L.Z., Rhee, L., and Kane, R.L. "The Role of Geriatric Assessment Units in Caring for the Elderly: An Analytic Review." Journal of Gerontology, 37, 3 (1982), 513-521.

This article examines the use of specialized geriatric assessment units as a means of establishing a comprehensive assessment of the elderly patient's medical and psychosocial needs, to determine optimal placement and to provide therapy and rehabilitation. The authors conclude that "Geriatric assessment units can provide important positive impacts on health care for the elderly, including more thorough diagnoses, improved levels of physical and psychological functioning, and better placement decisions" (p. 513).

Stoller, E., and Earl, L. "Help with Activities of Everyday Life: Sources of Support for the Noninstitutionalized Elderly." The Gerontologist, 23, 1 (1983).

This paper explores the levels of functional capacity and patterns of assistance provided to noninstitutionalized older persons in a series of activities of daily living and personal care by family members, friends or neighbors, formal service providers or hired help. The analysis focuses on older persons of varying levels of functional capacity and with differences in the availability of potential informal helpers. The findings suggest that spouses are the primary source of help for married impaired elders, and adult daughters are the major helpers when a spouse is not present or when the level of support provided by the spouse is not sufficient. Helping networks increase in both size and scope as functional capacity declines.

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APPENDIX A

Mental Status Questionnaire

1. Where are we now?
2. Where is this place (located)?
3. What is today's date - day of month?
4. What month is it?
5. What year is it?
6. How old are you?
7. When is your birthday?
8. What year were you born?
9. Who is President of the U.S.?
10. Who was President before him?

Scoring: 0-2 errors: chronic brain syndrome - absent or mild
3-8 errors: chronic brain syndrome - moderate
9-10 errors: chronic brain syndrome - severe
nontestable: chronic brain syndrome - severe

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APPENDIX B

Katz Index of Activities of Daily Living

The Index of Independence in Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to the toilet, transferring, continence, and feeding. Specific definitions of functional independence and dependence appear below the index.

A	Independent in feeding, continence, transferring, going to toilet, dressing, and bathing.
B	Independent in all but one of these functions.
C	Independent in all but bathing and one additional function.
D	Independent in all but bathing, dressing, and one additional function.
E	Independent in all but bathing, dressing, going to toilet, and one additional function.
F	Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G	Dependent in all six functions.
Other	Dependent in at least two functions, but not classifiable as C, D, E, or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he is deemed able.

BATHING (Sponge, shower or tub)

Independent: assistance only in bathing a single part (as back or disabled extremity) or bathes self completely.

Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bathe self.

DRESSING

Independent: gets clothes from closets and drawers; puts on clothes, outer garments, braces; manages fasteners; act of tying shoes is excluded.

Dependent: does not dress self or remains partly undressed.

GOING TO TOILET

Independent: gets to toilet; gets on and off toilet; arranges clothes, cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical supports).

Dependent: uses bedpan or commode or receives assistance in getting to and using toilet.

TRANSFER

Independent: moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports).

Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers.

CONTINENCE

Independent: urination and defecation entirely self-controlled.

Dependent: partial or total incontinence in urination or defecation; partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans.

FEEDING

Independent: gets food from plate or its equivalent into mouth (precutting of meat and preparation of food, as buttering bread, are excluded from evaluation).

Dependent: assistance in act of feeding (see above); does not eat at all or parenteral feeding.

Source: S. Katz, A.B. Ford, R.W. Moskowitz, B.A. Jackson, and M.W. Jaffee, "Studies of Illness in the Aged. The Index of ADL: A Standardized Measure of Biological and Psychosocial Function," *Journal of the American Medical Association* 185 (1963): 94 ff.

Measures of Physical Functioning

Evaluation Form

Name ____________________ Date of Evaluation ____________________

For each area of functioning listed below, check description that applies. (The word assistance means supervision, direction of personal assistance.)

BATHING--either sponge bath, tub bath, or shower.

___ Receives no assistance (gets in and out of the tub by self if tub is usual means of bathing).
___ Receives assistance in bathing only one part of the body (such as back or leg).
___ Receives assistance in bathing more than one part of the body (or not bathed).

DRESSING--gets clothes from closets and drawers--including underclothes, outer garments and using fasteners (including braces, if worn).

___ Gets clothes and gets completely dressed without assistance
___ Gets clothes and gets dressed without assistance except for assistance in tying shoes.
___ Receives assistance in getting clothes or in getting dressed or stays partly or completely undressed.

TOILETING--going to the "toilet room" for bowel and urine elimination; cleaning self after elimination and arranging clothes.

___ Goes to "toilet room", cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning).
___ Receives assistance in going to "toilet room" or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode.
___ Doesn't go to room termed "toliet" for the elimination process.

TRANSFER

___ Moves in and out of bed as well as in and out of chair without assistance (may be using abject for support such as cane or walker).
___ Moves in or out of bed or chair with assistance.
Doesn't get out of bed.

CONTINENCE

___ Controls urination and bowel movement completely by self.
___ Has occasional "accidents".
___ Supervision helps keep urine or bowel control; catheter is used or is incontinent.

FEEDING

- ____ Feeds self without assistance.
- ____ Feeds self except for getting assistance in cutting meat or buttering bread.
- ____ Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids.

INTERGENERATIONAL FAMILY DYNAMICS: FAMILY DEVELOPMENT, INDIVIDUALIZATION AND SEPARATION

This module is designed to provide trainees with a multigenerational perspective for use in the family assessment and treatment process. It is intended to help practitioners appreciate that the developmental tasks of the last life stage, as with all stages of the life cycle, involve the older adult as a member of his/her family system. Issues of diversity, research, multigenerational dynamics, treatment, and policy are discussed.

The objectives of this module are to:

- Provide definitions of multiple family forms;
- Outline current demographic trends and their effects on family structure and caregiving;
- Present information on systems and family life cycle theory;
- Describe some of the major developmental tasks of the later stages of the life cycle, particularly development of a mutual aid system and adaptation to loss;
- Present methods of intergenerational intervention;
- Outline current social policies affecting the family of later years.

This should enable trainees to:

- Understand and work with families of various cultural backgrounds and forms;
- Assess family dynamics and coping styles;
- Appreciate the stress of caregiving and make interventions to alleviate it;
- Treat the family as a system.

Definitions of Family

The extended family is all persons related to one another by blood and marriage (Butler & Lewis, 1982). The extended family may include other relatives added to the nuclear household (Billingsley, 1968).

A family is comprised of those who consider themselves economically and emotionally related to each other by blood (consanguinity) or by marriage (conjugality) (Butler & Lewis, 1982, p. 150).

A nuclear family consists of a married pair with dependent children and an independent household bound to outside kin by voluntary ties of affection and duty (Butler & Lewis, 1982). The nuclear family includes three types: the incipient, consisting only of marital pair; the simple, consisting of marital pair and minor children; and the attenuated, consisting of one parent and minor children (Billingsley, 1968, pp. 15-21).

The expanded family is comprised of either biologically related extended family and/or those who voluntarily associate as such (Boulding, 1972, p. 188).

A family is a system of related and unrelated individuals integrated by patterns of social relationships and mutual help (White House Conference, Report of Technical Committee, 1981).

The augmented family includes types of family situations wherein unrelated family members are incorporated into the household (Billingsley, 1968).

A family is a small social system made up of individuals related to each other by reason of strong reciprocal affection and loyalties, and comprising a permanent household (or cluster of households) that persists over the years and decades (Terkelson, 1980, p. 23).

Sample Discussion Questions and Issues

In what ways are these definitions similar/different?

Do these definitions encompass "new views" of family systems? If so, what are they and how do they differ from the traditional concept of family in this culture?

Characteristics of the Intergenerational Family

The purpose of this unit is to assist trainees to develop an appreciation of the diversity of family styles and the cultural variation(s) in establishing family boundaries and kin relationships.

Definition

Over the last several decades, the family has undergone many changes that have resulted in new and different situations that need to be addressed in human service delivery. During the 1950s, when family therapy first became a well-recognized treatment approach, the family was thought of as the marital pair, minor children, and extended family members related by blood. Only seven percent of today's families "fit" with this traditional form (husband-breadwinner, housewife, and two dependent children). As family styles have developed and changed and family life is more broadly defined, there exists a "whole new possibility of kin networks" for the older adult (Butler & Lewis, 1982).

In order to appropriately engage families as a source of support and assistance for older members, the human service worker must understand that people of different backgrounds may perceive family boundaries and responsibilities differently, and that these perceptions can affect the patterns of help and social and emotional support available across generations and between kin (Woehrer, 1978). At the same time, every family is comprised of persons who interact in relatively long-term relationships and perform affective and instrumental roles. The ability to identify, mobilize and assist these families is at the heart of intergenerational family intervention.

Sample Discussion Issues and Questions

A discussion can be focused on the participants' professional/experiential/personal views on what constitutes a "normal" family, and how this may affect their practice. Allow time for case examples and work-related experiences to facilitate this process.

What are the factors influencing changes in family styles? What impact do these changes have on the elderly?

Example: Inavailability of children and grandchildren due to geographic distance.

Example: Development of familial relationships and assumption of responsibility by significant others in a person's life.

Example: An increasing number of women working outside the home.

New Information and Practice Implications

The aim of this unit is to explore the relationship of research findings and trend analysis data on the intergenerational family, and how these relate to practice. Selected articles dealing with parent-care as a normative crisis are discussed.

Demographic Trends and Family Caregiving

- An individual born in 1900 could expect to live an average of 49 years. By 1981, life expectancy at birth had jumped to almost 74 years.
- Women now outlive men by a ratio of three to two.
- Life expectancy for blacks is an average five years less than for whites.
- In 1900, four percent (4%) of the total population, or 3 million people, were over 65; today there are 11 percent (11%), or 25 million persons, in this age group. The elderly non-white population has grown faster than the elderly white population.
- The fastest-growing segment of the American population is the 75-year-old-plus group. By the end of this century, they will number 5.1 million.
- Four out of five older people have children; almost half have great-grandchildren. This means that the number of four-generation families is increasing.
- About ten percent (10%) of all elderly people have a child who is also elderly. Black families are most likely to fall in this category.
- Families provide approximately 80 percent (80%) of all home health care.
- Forty-six percent (46%) of all widows have cared for their husbands at home before their deaths, forty percent (40%) of these for more than one year.
- Ten percent (10%) of elderly persons living in the community are bedfast or housebound. Another six to seven percent (6-7%) leave their homes only with great difficulty.
- A little over four percent (4.2%) of the over-65 community population have senile dementia.

- Almost twenty-four percent(23.7%) of individuals 65 and over are considered poor or "near poor" according to government poverty level indices, compared to 19.8 percent of the population under 65 years of age.

- One-third of all elderly (8 million persons) need supportive services, such as shopping service, housekeeping, transportation, etc.

- The vast majority of services to elderly people are provided by women: wives, daughters, and/or daughters-in-law.

- Between 1950 and 1980 the labor force participation of women between the ages of 45 and 54 rose from 38 to 60 percent; for those between the ages of 55 and 64, it rose from 27 to 42 percent.

Research and Intergenerational Relationships

It is important for practitioners to keep abreast of new theoretical and empirical information on intergenerational relationships, and to apply this information in practice. Particularly important is the slowly growing body of literature on diverse family systems. Today, family structures vary considerably, including single-parent families, blended families, two-paycheck couples, and intergenerational communes. There is also a sizeable group of childless elderly who depend on siblings or more distant relatives for support (Adams, 1976; Johnson & Catalans, 1981; Ward, 1979). Family dynamics and coping styles may also vary depending upon ethnic/minority group membership (McAdoo, 1981). By keeping up to date with current research, practitioners in gerontology will be better prepared to serve their clients within their cultural context.

One area in which there has been considerable research interest is family caretaking. Studies have documented that parents generally live in close geographic proximity to at least one adult child, maintain mutually close ties, and receive various kinds of assistance from one another (Brody et al., 1983; Robinson & Turner, 1979). While the family continues to be the major source of support for its elderly members, there is increasing concern in both the research and practice communities about how this critical caretaking function will be fulfilled in the future. The manner in which children are able to meet their filial responsibilities and deal with the "normal crises" of parent-care is really just beginning to be understood. The role of respite care and its relationship to relieving family stress is also first being explored (Brody, November 1984).

Bibliographic References

Some examples of research studies which have examined intergenerational relations involving issues of dependency and care are:

Brody, E. "Parent Care as a Normative Family Stress." The Gerontologist, 25, 1 (1985), 19-29.

This article argues that parent care has become a normative but stressful experience for individuals and families and that its nature, scope, and consequences are not yet fully understood. Some of the complex factors that interact to determine filial behavior are explored. A hypothesis is advanced that may explain the myth that adult "children nowadays do not take care of their elderly parents as was the case in the good old days." The research conducted by Brody et al. to date is summorized and suggests that parent care is not a single "stage" that can be fitted neatly into an orderly sequence of stages in the life course. Rather, it may be only one phase of caregiving that is increasingly extending into late middle and old age.

Brody, E. "'Women in the Middle' and Family Help to Older People." The Gerontologist, 21, 5 (1981).

This article outlines two major trends that have been taking place concurrently and have potential for affecting family care of the elderly: One is the greatly accelerated rate of increase in the very old population. The other is the large-scale entry of women into the work force. The author explores what effects these demographic changes have produced for the "women in the middle." Research findings and filial attitudes are also discussed.

Brody, S.J., Poulshock, W.W., and Masciocchi, C.F. "The Family Caring Unit: A Major Consideration in the Long-Term Support System." The Gerontologist, 18, 6 (1978), 561-569.

This study is an attempt to provide new data for long-term care planning. It identifies the variables which govern the institutional or community placement of the functionally disabled elderly. It was found that differential levels of functioning ability alone did not predict placement. The critical variables were living arrangement (living with spouse and/or children), socioeconomic status, and mental impairment.

Robinson, B.C. "Validation of a Caregiver Strain Index." [See appendix.] Journal of Gerontology, 38, 3 (1983), 344-348.

This paper outlines the development of a Caregiver Strain Index (CSI) which was validated on a sample of family, friends, and neighbors who provided varying degrees of care to recently hospitalized elderly.

The results indicate that the CSI is a brief, easily administered instrument which can identify strain on informal care providers. This index can also be useful in any interview or assessment package that examines intergenerational relations involving dependency and care.

Robinson, B., and Thurner, M. "Taking Care of Aged Parents: A Family Cycle Transition." The Gerontologist, 19, 6 (1979), 587-593.

This article presents the results of a research study on demographic and caretaking characteristics as they relate to parent-child relationships. The authors conclude that stress results from late-life parent-child relationships in two primary ways: coping with the perceived deterioration of the parent and experiencing the caretaking relationship as confining.

Steurer, J., and Austin, E. "Family Abuse of the Elderly." Journal of the American Geriatrics Society, 5, 28 (August 1980), 372-376.

This article discusses a series of case studies of disabled elderly persons who are abused by caretakers. A majority of the abused were women. Caretakers included spouses, children, siblings, or other relatives. Abuse was physical, verbal, and psychological. Misuse of medical therapy and nutrition were among other areas of physical abuse. Psychologic abuse included derogation, infantilization, and threats of institutionalization, abandonment, and homicide. Various recommendations are made for intervention and treatment of abusive families.

Zarit, S., Reever, K., and Bach-Peterson, J. "Relatives of the Impaired Elderly: Correlates of Feelings of Burden." [See appendix B] The Gerontologist, 20, 6 (1980), 649-655.

This article explores factors which contribute to feelings of burden in caregivers of senile dementia patients. The amount of burden experienced by caregivers was found to be less when more visits were paid to the dementia patient by other relatives. The results suggest the importance of providing support to caregivers as a critical step in the community care of elderly persons with dementia. The twenty-nine questions which make up "The Burden Interview" can be helpful to the practitioner in assessment (see D. Sands, Clinical Comments - "Use of the Burden Interview in an Adult Day Care Setting," The Clinical Gerontologist, 3, 2 (Winter 1984), 37).

Sample Discussion Issues and Questions

Trainees can be asked to describe the family dynamics and coping styles of the ethnic/cultural groups to which their clients belong.

Group discussion may then be focused on the implications of ethnicity, culture, socioeconomic status, geography, etc. on: (1) attitudes toward the elderly, (2) ability and (3) willingness to care for elderly parents. What do we know? How have we obtained that knowledge? What are the stereotypes of adult child-parent relationships for various cultures?

What anticipated demographic trends may affect the family's ability to continue to care for its elderly members? How will the care of the elderly be affected by these changes and what implications do they have for future service needs of the elderly?

Suggested Training Activities

In order to understand caretaking as a possible source of stress for the family, demographic trends must be translated into the everyday realities of their impact on family dynamics. This objective may be achieved by providing concrete data for the participants. For example, the information contained on pages 6 and 7 of this module may be duplicated and distributed to participants. Case examples which illustrate a particular demographic fact(s) can then be elicited from participants. For example, when discussing the fact that 10 percent of all elderly people have a child who is also elderly, a participant may know of a case in which the 85-year-old great-grandmother is admitted to a nursing home because her 60-year-old son has suffered a heart attack.

Participants should be given the opportunity to review "The Caregiver Strain Questionnaire" and "The Burden Interview," which are included in Appendices A and B to this module, and can be easily duplicated for handout. Both are recently developed research instruments which provide important assessment questions for evaluating persons-at-risk. Trainees could also use role play to administer the questionnaires to each other and then be required to develop a plan for services that would help to meet the identified areas of need.

The Older Adult Within the Family System

The objective of this unit is to provide information on the older adult as a member of his/her family system. Content focuses on systems theory, family life cycle development concepts, and the major phase-specific tasks of the family of later years, including adjustment to loss. However, because there has been much material developed and training available on death and dying, that subject will not be emphasized here.

Human Behavior

One of the more recently developed concepts available to the professional in the field of aging is the family life cycle theory. While the family therapy movement began in the early 1950s, explicit reference to the life cycle as a useful framework for practitioners did not appear in the family therapy literature until the 1970s (Carter & McGoldrick, 1980). The life cycle perspective suggests that a focus on the family as an evolving unit can offer a useful therapeutic approach. This important concept is a synthesis of developmental and systems thinking about the family. It suggests that the family is an adaptive unit with critical resources for the continued growth and maturation of its members. It also assumes that:

> Each stage in the life cycle of the family is characterized by an average expectable family crisis brought about by the convergence of biopsychosocial processes which create phasespecific tasks to be confronted, undertaken and completed. These family tasks reflect the assumption that developmental tasks of individual family members have an overriding influence or effect on the nature of family life at a given time, and represent family themes that apply to family members as individuals as well as groups (Rhodes, 1980, p. 31).

While there seems to be general agreement that the process of making the transition from phase to phase throughout the life cycle involves considerable stress, there is no consensus as to what tasks constitute the developmental issues of a particular stage. Walsh (1980) suggests that the family of later life must deal with retirement, widowhood, grandparenthood, illness and dependency. Rhodes (1980) maintains that the major task of the last stage in the life cycle of the family is to develop a mutual aid system; and Solomon (1973) proposes that during the final stage of development the family must learn to integrate economic, social and physical losses.

The suggestion that the major task of the last stage in the life cycle of the family is establishing a mutual aid system has received considerable attention in the literature (Blenker, 1965; Brody, 1985; Bowen, 1971). Blenker (1965) coined the term "filial crisis" to describe the process that takes place in adult children when it becomes evident that their parents are aging, and they as offspring will, at times, be called upon to support and care for them. Brody (1985) offers the hypothesis that parent care has become a normative but stressful experience for individuals and families; Motenko (1985) suggests that the family relationships of older persons are maintained through a system of interdependence and exchange of goods and services. Help is provided across the generations by older persons receiving as well as giving help (p. 243). This allows us to appreciate the reciprocal nature of family helping.

The expectation that adult children and their elderly parents develop a reciprocal helping relationship can be problematic for some adult children. The successful achievement of this developmental task involves the renegotiation of the parent-child relationship to one of adult to adult. This ideally takes place throughout the life of the family members and requires the development of "a structure of respect and cooperation" (Rhodes, p. 39).

Another major task associated with the last stages of the family life cycle is adaptation to loss. Loss is a natural part of the life cycle, occurring from childhood to death, and is also a "natural" component of intergenerational dynamics. However, for many families, prolonged illness and the death of a member may come just at the point when emotional, social, and financial resources are depleted, and the family system is particularly vulnerable. Coping with illness and death is increasingly a responsibility shared among the family and formal organizations such as hospitals, nursing homes, hospices, and other long-term care facilities. Caroff and Dobrof (1975) suggest that the role of the practitioner in such instances is to "honor grief and recognize its normality," yet be alert to the potential for family dysfunction if the demands on the system are too great.

Although individuals experience loss throughout life, for the elderly losses tend to be multiple. Retirement results in loss of work role identity and reduced income. Spouses, relatives and friends begin to die. Sequential losses may be triggered by the loss of physical capacities and functional abilities such as hearing, movement, etc., resulting in removal of the elderly person from familiar physical environments of home and community, and separation from family, friends and neighbors.

The significance of each loss is individual and subjective, as is each persons's reaction to loss. Past losses, which may or may not be resolved, can affect reactions to current situations. The level and type of support available to an individual experiencing loss also influences that individual's response. The grieving process can include: shock, disbelief, numbness, confusion, anger, guilt, depression--sleeping and eating irregularities, irritability, restlessness, anxiety and poor concentration. The process of acute grief usually occurs over 6 to 12 months, but can take longer for some individuals. Grief can remain unresolved for years, especially if a person denies the occurrence of the loss or the feelings regarding it. Where culturally appropriate, the practitioner can assist in the grief process by encouraging clients to talk about the loss and accept their feelings about it. Individuals experiencing a reaction to loss should be discouraged from making any major decisions or changes in their life until the grief is resolved.

An emphasis on family developmental stages and their phase-specific tasks, such as dealing with dependency and loss, places later life transitions in their proper context. During the later stages of life, as with all stages of development, family members are involved in meeting normal (family) developmental crisis. How the family copes in later years is in large measure dependent upon "the type of system they have created over the years and the ability and modes of the system to adjust to losses and new demands" (Walsh, 1980, p. 199). The practitioner needs to become aware of how to assess these life cycle issues, and when necessary be prepared to assist the family in coping with the major adaptational changes of later life.

Sample Discussion Questions and Issues

Trainees can be asked to recount from their experience the developmental tasks and issues they believe to be associated with aging.

What effect does parent-care have on the lives of the adult children involved?

What roles can the elderly perform in society?

What do our societal values say about the elderly?

Describe various reactions to loss. Identify which of these are adaptive/coping mechanisms and which are maladaptive.

What interventions can be made when a family or individual reaction to loss is dysfunctional?

Suggested Training Activities

The Collett/Lester Fear of Death Scale, Likert Attitude Inventory Scale, is provided in Appendix E to this module. It can be duplicated and distributed for participants to explore their own attitudes and beliefs about death and dying. From this activity a discussion can focus on participants own views of death--do they conceptualize death as part of the life cycle?--their reactions to the deaths of relatives and friends, and the way in which they address the issue of death with their clients.

It is important for instructors to understand their own views of death and dying and have their feelings in perspective in order to be comfortable discussing the topic.

Family-Focused Treatment Methods

The goal of this unit is to assist participants to use family-focused methods in professional practice with the aged. Participants will be shown the importance of addressing presenting problems in family terms, and reaching out to family members who may not always be available for direct participation in the helping process.

Material is introduced, such as genograms and ECO maps, that permit the practitioner to understand the older person in interactional terms (Shulman, 1979).

Methods

Intergenerational approaches to family therapy, which are relatively new treatment modalities, begin with the recognition of the family as a system, and rest on the assumption that there are strong connecting ties between the generations. These reciprocal ties may be observed in the form of physical caretaking, telephoning, visiting, writing and the showing of interest and concern. The idea of the isolated or totally independent nuclear family is a myth, and the boundaries of the family must be seen as encompassing all generations (Bowen, 1978; Spark, 1974).

While intergenerational forms of treatment are slowly emerging, there are several new models on which to draw (Eyde & Rich, 1983; Greene, 1985; Silverstone & Burack-Weiss, 1983). Eyde and Rich provide a model for family case management; Silverstone and Burack-Weiss a framework for social work practice with the frail elderly and their families; and Greene a method of assessment and treatment of an older adult within a family context. These theories all present principles of family dynamics in which the elderly person is seen as a functioning member of the family group and problems are evaluated in relation to the interactional (family) system. Efforts are made to reach out to family members and the presenting problem is addressed in family terms. Understanding the family as a system enables the caseworker to more effectively mobilize all members on behalf of the older adult.

In most settings where practitioners work for and with the aged, family focused casework centers around a crisis involving the older adult. Involvement of the family at the time of crisis can mean their continued participation. This is particularly true for the older person entering a nursing home where facilitating the maintenance of family ties is often the role of the social worker (Greene, 1982).

Herr and Weakland (1979) suggest that there are eight general steps for providing counseling to elders and their families:

(1) establishing initial contact with the clients;
(2) inquiry and definition of the problem;
(3) inquiring into handling the problem;
(4) inquiry as to minimal goals;
(5) observation of the positions of the identified patient and others;
(6) review and strategic planning;
(7) further interviews, specific interventions, and evaluation of their effects; and
(8) termination.

While originally designed for practice with younger families, genograms and ECO maps are particularly valuable in gathering information about the client system. If the practitioner is flexible in their use, making modifications as necessary, he/she will find that these tools can simultaneously engage the client(s), and make them collaborators in history-taking and assessment (Guerin & Pendgast, 1976; Hartman, 1979). Most older people respond positively to questions about their past as a normal part of the life review process, making this aspect of history taking a pleasant and therapeutic experience.

A genogram is an expanded "family tree." It uses the symbols, as presented below, and allows the practitioner and client to have a visual representation of the family group.

□ = male ○ = female

horizontal line = marriage

vertical line = offspring

(date)
broken line = divorce
- - - - - -

☒ or ⊗ = death

An ECO map is a simplified diagram of the family's surroundings/significant others, institutions, and community. It is useful in visualizing the "degree of fit" or "the energy exchange between the family and other systems directing the caseworker to potential resources for the client" (Gafford & Gates, 1983).

In short, families continue to be the primary source of support for the frail and/or impaired elderly. However, families are often frustrated by fragmented and/or uncoordinated services. While intergenerational family therapy is still in its infancy, there are a growing number of practice models from which to draw (Eyde & Rich, 1983; Greene, 1985; Silverstone & Burach-Weiss, 1983). These models suggest that the professional must unite with older people, their families, and with each other, in a team approach. The goal is to support, not supplant, the family system.

Sample Discussion Questions and Issues

What are the pluses and minuses of the intergenerational approach to family therapy?

Should multigenerational treatment always be used in working with the elderly? What might be some of the obstacles to its usefulness? In what ways can the family be involved?

Participants can be asked to relate their experiences involving working with the families of their clients.

Suggested Training Activities

Participants can be asked to role play the situation in which an elderly client who has been estranged from family members for years and does not want them informed and/or involved with her in any way, while the practitioner wants to reach out to family members as a resource for the client.

Participants should be encouraged to write autobiographies (Greene, 1983) or complete their own genograms, in order to become more aware of their own family influences (see appendix C).

Policy Issues

The objective of this unit is to increase participants' knowledge about the impact on service delivery of changing family structures and to identify how public policy constrains or enhances the parameters of practice. Particular local and state programs should be addressed.

Policy

The 1980 White House Conference on Aging has set the policy agenda for the decade, as the 1971 Conference focused on the policy issues for the succeeding period. In a "Report of the Technical Committee on Family, Social Services and Other Support Systems" at the 1980 Conference, key questions dealing with public policy and the role of the family were raised for consideration by the delegates.

In order for the family to continue in its critical function as primary caregiver, policy solutions must provide for the coordination of private and public resources and the necessary linkages between formal and informal support systems (Report of Technical Committee, 1981). See also Report of the Mini-Conference on Intergeneration Cooperation and Exchange, 1981, for recommendations for local and national political action.

Sample Discussion Questions and Issues

Practitioners in gerontology are often directly involved at the "frontline" with the difficulties presented by public policy. Therefore, the following questions, which were raised by the delegates at the 1980 White House Conference on Aging, can serve not only as a basis for discussion, but can also give direction to social action and ideas for social change.

How can public policy, programs and services strengthen and protect the role of families in fostering the continued independence of older people (e.g., the bias in reimbusement which favors institutionalization of the older person)?

How can newer forms of service be more effectively designed and financed to meet the needs of older adults and their families (e.g., whether the home-health care provided by families should be compensated and be covered under Medicare).

How can the disincentives in law and regulation, which discourage family support and service provision to older adults and their families be eliminated (e.g., whether the dependent care credit provision for tax exemptions now discourages families from using community-based care for the disabled elderly [These tax credits for out-of-home exemptions are now available only for children 14 and under]).

Should families be held financially responsible for the older relative under Medicaid?

How do the changes in the family structure reduce home-care options for the elderly?

Does current public policy suport or hinder in-home care?

Participants may also want to consider how changes in family structure will affect family roles and the need for services. Discussion can focus on the following changes, which are expected to place enormous demands on services:

- The declining birth rate
- Increased longevity
- The increased number of "old-old"
- The increased number of multigenerational families
- The increased participation of women in the labor force.

Summary of Practice Implications

Intergenerational forms of family therapy offer a method of assessment and treatment of an older adult within a family context. The focus is on the older person as a member of a family group and problems are evaluated in relation to the interactional (family) system. As such, intergenerational therapies provide a framework for viewing the family as the client system.

While most older people have family, many practitioners assume that the elderly person is the client. The main purpose of this unit is to help participants appreciate that the older person may be helped as part of a family. The ultimate goal is to increase knowledge regarding family dynamics, outreach strategies, and techniques for working with a family as a system.

Sample Discussion Questions and Issues

In order for participants to better develop their skills in using an intergenerational approach in working with the family, a series of case situations are presented below.

Case Examples
Biopsychosocial and/or Developmental Crises

1. An older adult who has recently broken a hip makes "excessive demands" of his youngest son.
2. A mildly confused mother is viewed by her "anxious" daughter as an "appropriate" candidate for nursing home placement.
3. A hospitalized stroke victim is visited daily for many hours by a "concerned" daughter.
4. A newly widowed grandmother moves into her oldest son's household, "upsetting the routine."
5. A recently retired grandfather becomes a "depressed shut-in," refusing to leave his home.
6. A newly retired grandmother moves to Florida, "abandoning" her daughter and handicapped grandchild.

The following questions can be used to foster discussion:

1. Who is the client?
2. How should the caseworker proceed at intake to involve the family?
3. How can the problem be defined in family terms?
4. What intervention strategies can best assist the family as a unit?

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Anderson, R., and Carter, I. *Human Behavior in the Social Environment.* New York: Aldine Publishing Company, 1978.

This basic human behavior text has a chapter on the family as a social system. It offers a synthesis of several conceptual frameworks that have been created to analyze the family, including (a) the family as a system of roles, (b) the family as an evolving system, (c) the structural approach, and (d) the functional approach. Definitions for family forms are also provided.

Berger, R., and Federico, R. *Human Behavior - A Social Work Perspective.* New York: Longman, Inc., 1982.

This book is intended to help social workers and other social welfare professionals become better able to utilize knowledge of systems theory as a guide to practice. It presents a clear picture of systems thinking as a means of understanding human behavior from a "contextual and interactional perspective." It also examines the life cycle with material on adulthood, retirement, and death as "life stages."

Boszormeny-Nagy, I., and Spark, G. *Invisible Loyalties.* New York: Harper and Row, 1973.

This book, which is devoted to family therapy and intergenerational reciprocity, devotes a full chapter to reciprocity among grandparents, parents and grandchildren. The authors postulate that the major connecting tie between the generations is that of loyalty based on the integrity of reciprocal indebtedness. This may be expressed in the form of physical caretaking, telephoning, visiting, respect and concern.

Brody, E., Johnson, P., Fulcomer, M., and Lang, A. "Women's Changing Roles and Help to Elderly Parents: Attitudes of Three Generations of Women." *Journal of Gerontology*, 38, *5* (1983), 597-607.

Data on the effect of women's changing roles on attitudes toward responsibility for care of elderly adults were gathered from three generations of women: elderly women, middle generation daughters, and young-adult granddaughters. The results are discussed in this article. The authors concluded that values about family care of elderly adults have not eroded despite demographic and socioeconomic changes.

Butler, R.N., and Lewis, M. *Aging and Mental Health.* St. Louis, MO: C.V. Mosby Co., 1982.

This is a revised edition of a widely-used *text* for mental health practitioners. It offers an overview of the major issues and problems associated with old age and in-depth coverage of assessment, treatment and prevention. It also provides chapters on Older People and Their Families, Organic Brain Disorders, and Special Concerns (racism, sexism, retirement, crime, alcoholism, deafness, blindness, and sexuality).

Carter, E., and McGoldrick, M., eds. *The Family Life Cycle: A Framework for Family Therapy*. New York: Gardner Press, Inc., 1980.

By charting the developmental progress of the entire three-generational family system, this book fills a major gap in the field. The authors, who are all family therapists, propose that problems are often the result of derailment in the family life cycle, and that the goal of therapy is to return the family to its course. The book offers a conceptual overview of the life cycle of the "middle-class American" family, followed by chapters defining the tasks required of family members at each stage of the life cycle. Clinical suggestions are also made. Special chapters include "The Family Life Cycle of the Multi-Problem Poor Family" and "Cultural Variations in the Family Life Cycle: The Mexican-American Family."

Collett, L., and Lester, D. "The Fear of Death and Fear of Dying." *Journal of Psychology*, 72 (1969), 179-181.

The Collett-Lester Fear of Death Scale, developed in 1969, attempts to distinguish between the fear of death and the fear of the process of dying and to differentiate between these fears depending upon whether they are for oneself or for another. The four subscales are: fear of death of self, fear of death of others, fear of dying of self, fear of dying of others.

Eyde, D. and Rich, J. *Psychological Distress in Aging: A Family Management Model*. Rockville, MD: Aspen Systems Corp., 1983.

This book provides a comprehensive model that organizes biopsychosocial variables and translates this integrated information in a utilitarian form for family caregivers. The authors stress the need to help families plan by understanding the biopsychosocial aspects of aging relatives. Suggestions are also made for dealing with the social and environmental needs of older adults.

Feifel, H., ed. *New Meanings of Death*. New York: McGraw-Hill, 1977.

This book, a revised edition of *The Meaning of Death* (1959), is a collection of readings about many facets of the processes of death and dying: developmental orientations, clinical management, survivors, and responses to death. Contributors include Robert Kastenbaum, Edwin Shneidman, Richard Kalish, and Daniel Leviton.

Gafford, L.S., and Gates, V. "Genograms, ECO-Maps, and Structured Outlines: Clients and Students Working Together on Psychosocial Assessments." Presented at the 29th Annual Program Meeting of the Council on Social Work Education. March 14, 1983.

This article discusses the use of genograms and ECO maps as a means of facilitating the students' psychosocial assessment of the client. This process is thought to help students identify and record significant information within the interview and simultaneously engage the client as a collaborator in the history-taking and assessment process.

Greene, R. "Families and the Nursing Home Social Worker." Social Work in Health Care, 1, 3 (Spring 1982), 57-67.

This article focuses on ways in which the social worker can facilitate a positive interaction among family members and can become a positive part of the life of the nursing home resident through social work intervention.

__________. "The Functional-Age Model of Intergenerational Therapy: A Social Casework Model." The Clinical Gerontologist, Special Issue, 1985.

This article presents a casework model of biopsychosocial variables for intergenerational family treatment for use by professionals interested in gerontology family therapy. It suggests innovative diagnostic and treatment modalities for problem-solving in crisis situations arising around family adjustment to the changing needs of its aging members. [This article is an overview of the author's text, Social Work with the Aged and Their Families. New York: Aldine, 1986, which contains in-depth assessment and treatment suggestions from both individual and family perspective.]

__________. "Life Review: A Technique for Clarifying Family Roles in Adulthood." Clinical Gerontologist, 1, 2 (Winter 1982), 59-67.

This article discusses the use of life review as a technique that can be helpful to older persons in clarifying their roles as family members. Life review can create a therapeutic milieu for resolving some of the conflicts that accompany the role changes associated with adulthood.

Herr, J., and Weakland, J. Counseling Elders and Their Families. New York: Springer, 1979.

This book remains one of the best in the field of family therapy with older adults because it provides a clear step-by-step approach for the therapist. The second half of the book is devoted to case studies and analytical comments and issues.

Hooyman, N.R., and Gottlieb, N. "Training for Mental Health Services to Older Persons." Paper presented at the Annual Program Meeting, Council on Social Work Education. Washington, DC, February 1985.

This is an excellent well-thought-out rationale for a multigenerational perspective in providing mental health services to the older adult. Implications for mental health services and social work curricula are also addressed.

Kastenbaum, R.J. *Death, Society and Human Experience*. St. Louis: C.V. Mosby Co., 1977.

Death is examined by Kastenbaum as a transitional event rather than as a developmental stage of life. This helps to provide some insight into care given dying persons. Also included are excellent chapters on bereavement as a process, grief and mourning and a complete list of additional reading.

Kubler-Ross, E. *On Death and Dying*. London: Macmillan, 1969.

This book is one of the most widely-read books on dying, death, and the terminal patient. Dr. Ross's pioneering work in interviewing terminal patients and describing the five stages of dying has become the foundation for much of the current interest in these topics.

Otten, A. "The Oldest Old." *The Wall Street Journal*, Monday, July 30, 1984, p. 1.

This article discusses the implications of the fact that increasing numbers of Americans are living into their eighties and nineties. In 1982, 2.5 million joined the ranks of the "oldest old," and by the year 2000, the United States Census Bureau predicts there will be 5.1 million people in this age group. As four and five generations become more commonplace, there will be increased demands placed upon the family system. Government spending policies, personal finances, family caretaking, and bioethical choices will also present issues of concern.

Pincus, L. *Death and the Family: The Importance of Mourning*. New York: Pantheon Books, 1975.

This book, through the use of personal memories of the author and some theory, explores the patterns of grief and mourning. It focuses on some aspects of bereavement which have been identified in other studies, such as the process of mourning and grief and the phases of adaptation, as well as repressed mourning.

Priddy, J.M., and Gallagher, D. "Clinical and Research Issues in the Study of Caregiver Support Groups." Paper presented at the 37th Annual Meeting of the Gerontological Society of America, San Antonio, Texas, November 1984.

This study, which was supported in part by a grant from the National Institute on Aging, examines major clinical and research issues of support groups for families of elders with memory loss and offers suggestions for others considering undertaking similar research. It concludes that the use of peer support groups with older adults, such as the Alzheimer's Disease and Related Disorders Association, have proven to be an effective intervention.

Rhodes, S. "A Developmental Approach to the Life Cycle of the Family." In M. Bloom, ed. *Life Span Development*. New York: Macmillan Publishing Company, Inc., 1983, pp. 30-40.

The purpose of this article is to identify stages in the life cycle of the family in the tradition of Erik Erikson's life cycle of the individual. The author suggests that each stage in the life cycle of the family is characterized by an average expectable family crisis brought about by the convergence of biopsychosocial processes which create phase-specific family tasks to be confronted, undertaken, and completed. Implicit in this suggestion is a synthesis of developmental and systems thinking. The major task of the last stage of life is to develop a mutual aid system which would combat generational disconnectedness and feelings of uselessness.

Schulman, G. "Teaching Family Therapy to Social Work Students." *Social Casework*, July 1976, pp. 448-457.

This is an approach to teaching family therapy in which the cognitive and the experiential process are interwoven. The material is relevant to academic settings, training institutes in agencies, workshops and continuing education programs.

Silverstone, B., and Burack-Weiss, A. *Social Work Practice with the Frail Elderly and Their Families*. Springfield, IL: Charles C. Thomas Publisher, 1983.

In this text, the authors examine the problems of the frail elderly, outline the practice skills required in addressing these problems, and introduce the auxiliary function model. In this model, family members and neighbors as well as social workers and other service providers share in the care of the frail elderly. The construction of the study, assessment and plan is described, as are the various settings in which frail elders are served. Professional issues of collective advocacy, protection of the client, job management, overload and burnout, and personal involvement are also discussed.

Solomon, M. "A Developmental Conceptual Premise for Family Therapy." *Family Process*, 12 (1973), 179-188.

This article discusses the premise that the treatment of the family provides the optimum arena in which problem-solving and conflict resolution may take place. In this treatment the developmental stages of the family must be taken into account as all families are likely to experience some disorganization and pressure at each stage. In the last developmental stage, integration of loss is the major developmental task.

Spark, G. "Grandparents and Intergenerational Family Therapy." Family Process, 13, 2 (June 1974), 225-237.

Spark suggests that intergenerational family therapy which deals with "unfinished business" between parents and grandparents facilitates structural as well as symptomatic changes in the family system. As unresolved loyalty conflicts and unsettled accounts between first and second-generation family members are often projected onto, or lived out, in the marital or parental relationship, the caseworker should address intergenerational family dynamics in both assessment and treatment.

Streever, K.L., and Wodarski, J.S. "Life Span Developmental Approach: Implications for Practice." Social Casework, May 1984, pp. 267-278.

This article discusses the life span developmental approach which suggests that individuals can change and grow in adulthood. The characteristics and tasks of each psychosocial stage are presented and implications for the practitioner's intervention at each stage are discussed. The author suggested that in later adulthood (51 years and beyond) the individual is faced with the developmental tasks of accepting one's life, redirecting energy to new roles and activities, formulating new relationships between generations, and developing a point of view about death.

The 1981 Social Change White House Conference on Aging. Report of the Mini-Conference on Intergenerational Cooperation and Exchange. Washington, DC: The Department of Health and Human Services, 1981.

A shortage of opportunities exists for both youth and older persons to be active, contributing members of society. At the same time, there exists a shortage of financial and human resources available to meet the needs of both young and old. Increased intergenerational cooperation and exchange can enable the simultaneous development of meaningful roles and needed services for individuals of all age groups. This report sets forth an agenda for the 1980s for strategies for linking the generations. Most of the programs are at the local level with an emphasis on policy recommendations.

The 1981 White House Conference on Aging. Report of Technical Committee on Family, Social Services and Other Support Systems. Washington, DC: The Department of Health and Human Services, 1981.

The focus of this report is on the older person as an individual and the sources of financial, psychological and social supports that assist the individual to retain independence in the Community to the greatest extent possible. Family is defined here as a system of relocated and related individuals, integrated by patterns of social relationships and mutual help. The service system is composed of public and private agencies and programs that provide income maintenance, health, and social services. Support systems are individuals and groups that provide "informal" service "as needed" and respond in time of crisis.

U.S. Senate Special Committee on Aging and American Association of Retired Persons. Aging America. Trends and Projections, 1984.

This chartbook is designed to provide information on the general characteristics, diversity and change within the older population for use as a comprehensive resource for all those concerned about aging and social policy. It contains excellent, clear graphics.

Woehrer, C.E. "Cultural Pluralism in American Families: The Influence of Ethnicity on Social Aspects of Aging." The Family Coordinator Journal Special Issues on: Aging in a Changing Family Context, 27, 3 (October 1978), 333.

This article addresses "the way in which people of different ethnic backgrounds perceive family boundaries, responsibilities, and expectations and the effect on patterns of help and social and emotional support between generations and kin. The author suggests that to be fair to Americans of all backgrounds, policies and programs need to be varied and flexible, and alternatives appropriate to the aged of all cultural backgrounds available.

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AUDIOVISUAL RESOURCES

"Peege." 16mm film/Color - 28 minutes, 1975.
Available from Phoenix Films.

A feeling of worth and knowing someone cares are shown to be important needs at any stage of life. A family visits a dying grandmother in a nursing home. She is blind and has lost some of her mental faculties. The visit is awkward and when the family leaves, the young grandson stays with her for a few lingering minutes. He whispers in her ear, touches her, and is successful in triggering a response. The communication barrier has been broken. When he leaves, she is again alone, but knows someone cares.

"Weekend." 16mm film/Color - 12 minutes, 1973.
Available from Mass Media Ministries.

Without dialogue of any kind, we watch a sad ritual take place as the nuclear family disposes of what it can no longer contain--the aged parent. In a highly symbolic display, the family conducts itself on a picnic in the country. Nothing unnatural or unusual appears to be happening, until gradually it becomes apparent that for the elderly man, it is a one-way trip. This film will probably provoke resentments as well as sentiment, so it serves well to stimulate discussion.

"When Parents Grow Old." 16mm film/Color - 16 minutes, 1970.
Available from Learning Corporations of America or Syracuse University.
Prices on request.

Working with the aged client means having to work with the client's family too. In this film, edited from the fine feature film, "I Never Sang for My Father," the conflict between filial responsibility and a son's desire to have a life of his own is left unresolved. This conflict provides for discussion of the role of "family responsibility."

APPENDIX A

Caregiver Strain Questionnaire

I am going to read a list of things which other people have found to be difficult in helping out after somebody comes home from the hospital. Would you tell me whether any of these apply to you? (GIVE EXAMPLES)

	Yes = 1	No = 0
Sleep is disturbed (e.g., because ____ is in and out of bed or wanders around at night	____	____
It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help)	____	____
It is a physical strain (e.g., because of lifting in and out of a chair; effort or concentration is required)	____	____
It is confining (e.g., helping restricts free time or cannot go visiting)	____	____
There have been family adjustments (e.g., because helping has disrupted routine; there has been no privacy)	____	____
There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation)	____	____
There have been other demands on my time (e.g., from other family members)	____	____
There have been emotional adjustments (e.g., because of severe arguments)	____	____
Some behavior is upsetting (e.g., because of incontinence; ____ has trouble remembering things; or ____ accuses people of taking things)	____	____
It is upsetting to find ____ has changed so much from his/her former self (e.g., he/she is a different person than he/she used to be)	____	____
There have been work adjustments (e.g., because of having to take time off)	____	____
It is a financial strain	____	____
Feeling completely overwhelmed (e.g., because of worry about ____; concerns about how you will manage)	____	____
Total Score (count yes responses)	____	

B. Robinson, in Journal of Gerontology, 38, 3 (1983), 344-348.

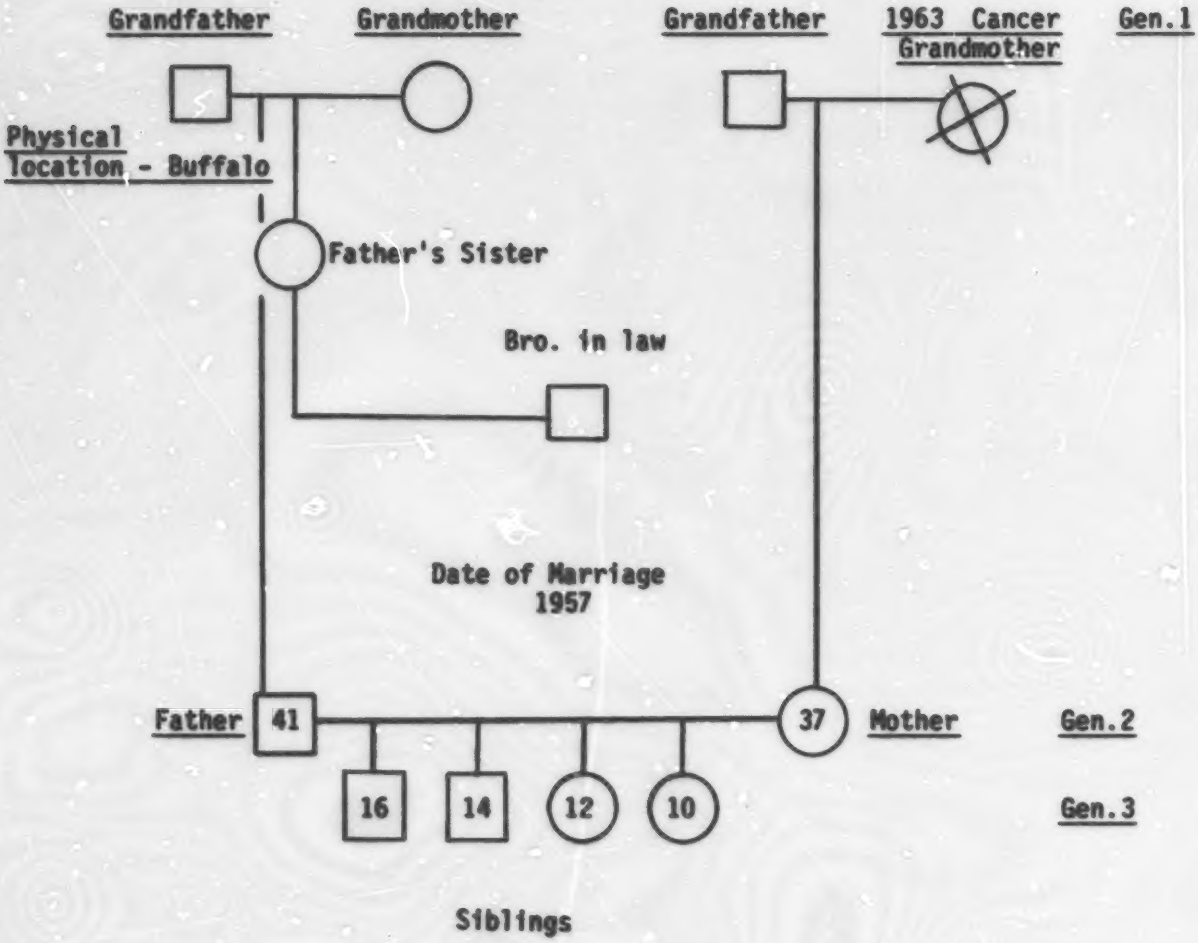
APPENDIX B

The Burden Interview

1. I feel resentful of other relatives who could but who do not do things for my spouse.
2. I feel that my spouse makes requests which I perceive to be over and above what she/he needs.
3. Because of my involvement with my spouse, I don't have enough time for myself.
4. I feel stressed between trying to give to my spouse as well as to other family responsibilities, job, etc.
5. I feel embarrassed over my spouse's behavior.
6. I feel guilty about my interactions with my spouse.
7. I feel that I don't do as much for my spouse as I could or should.
8. I feel angry about my interactions with my spouse.
9. I feel that in the past I haven't done as much for my spouse as I could have or should have.
10. I feel nervous or depressed about my interactions with my spouse.
11. I feel that my spouse currently affects my relationships with other family members and friends in a negative way.
12. I feel resentful about my interactions with my spouse.
13. I am afraid of what the future holds for my spouse.
14. I feel pleased about my interactions with my spouse.
15. It's painful to watch my spouse age.
16. I feel useful in my interactions with my spouse.
17. I feel my spouse is dependent.
18. I feel strained in my interactions with my spouse.
19. I feel that my health has suffered because of my involvement with my spouse.
20. I feel that I am contributing to the well-being of my spouse.
21. I feel that the present situation with my spouse doesn't allow me as much privacy as I'd like.
22. I feel that my social life has suffered because of my involvement with my spouse.
23. I wish that my spouse and I had a better relationship.
24. I feel that my spouse doesn't appreciate what I do for him/her as much as I would like.
25. I feel uncomfortable when I have friends over.
26. I feel that my spouse tries to manipulate me.
27. I feel that my spouse seems to expect me to take care of him/her as if I were the only one she/he could depend on.
28. I feel that I don't have enough money to support my spouse in addition to the rest of our expenses.
29. I feel that I would like to be able to provide more money to support my spouse than I am able to now.

S. Zarit, K. Reever and J. Bach-Peterson, in The Gerontologist, 20, 6 (1980), 651.

APPENDIX C


Grandfather
Grandmother
Grandfather
1963 Cancer
Grandmother
Gen.1
Physical
location - Buffalo
Father's Sister
Bro. in law
Date of Marriage
1957
Father
41
37
Mother
Gen.2
16
14
12
10
Gen.3
Siblings

APPENDIX D

Case Vignette
Who Really Cares About Alzheimer's Disease?

Mr. Zimmer was discharged from the skilled care unit of the Lennox City Nursing Home. Many staff members were there to say goodbye to this man who had spent the last five months recuperating from a fractured hip. Mr. Zimmer's rehabilitation had been complicated by the fact that, for the past three years, he had been exhibiting symptoms which led his physician to diagnose him as having Alzheimer's disease. June Adams, the medical social worker on the skilled care unit, could not help but feel a sense of sadness as she watched Mr. Zimmer being wheeled down the coridor by his fifty-year-old daughter and his seventy-year-old wife. June believed that the growing number of patients identified as having Alzheimer's disease necessitated the initiation of some type of community action for the patients and their families.

General Background

The social services department at the Lennox City Nursing Home has been in existence since the facility first opened fifty-two years ago. It offers many services to the patients, including information and referral, support to both the patients and their families, and discharge planning. Through the years the number of medical social workers has grown to include three full-time positions. June had recently been hired as the social worker in the skilled care unit, a position which had previously been filled by a woman who had a nursing background. June was hired at a time when the nursing home started to upgrade many of its positions to meet the demands of the growing community and the expanding geriatric population.

June had previously worked in a large metropolitan area. She was employed in a nursing home for three years after receiving her Bachelor's of Social Work degree. She then went to work in a general hospital. While in that position, June worked on a stroke rehabilitation unit along with another social worker and other members of an interdisciplinary team. After a year and a half, June decided to return to school to earn her Master's in Social Work. However, due to an unexpected family problem, she returned after completing half of the curriculum to live in Lennox, the small southern city of her childhood.

June's knowledge, expertise, and experience were welcomed at the nursing home in Lennox. In the short time that June had been there, she had developed a support group for stroke victims and their families. She had also helped to improve the nursing home's reputation in the community through interactions with various community resources, including hospitals, church and civic groups, and social service agencies.

June's efforts to initiate the stroke support group came from her experience in working with patients and their families on an individual basis and realizing that these persons could benefit from each other's experiences. The topics of the stroke support group ranged from education and prevention to emotional support. From this work, June began to make others aware of the importance of group work as a support system for patients and their families with a chronic, debilitating disease.

Mr. Zimmer had been admitted to the nursing home following surgery for the repair of his fractured right hip. June interviewed Mr. Zimmer and his family in order to obtain a psychosocial history and to make a needs assessment with regard to discharge planning. Mr. Zimmer's wife, Betty, had been taking care of her husband for the past several years. At the time of her husband's admission, Betty was on the verge of exhaustion. During the past year, Mr. Zimmer had become increasingly forgetful and he had started to wander about the house at night. The night Mr. Zimmer fell and broke his hip was a night when he had gotten free of his vest restraint and had fallen down the stairs. The Zimmers' daughter had flown in from out of town and planned to stay with her parents until they could manage without her.

Placement: Difficulties and Dilemmas

June had been frustrated in her efforts at placing Mr. Zimmer into an intermediate care nursing home. Many homes had long waiting lists, two had refused to take clients with Alzheimer's disease, and several were simply too expensive for the family. The Zimmers decided to try to "manage at home a little longer."

June was upset. Mr. Zimmer was one among many clients admitted to the unit with advanced Alzheimer's disease. She had struggled to find appropriate placements for these clients when it was apparent that their disease had advanced to a stage beyond what their families could manage at home. Often her efforts were frustrated by lack of services or by the expense of those that were available.

June decided to contact area nursing homes, acute care hospitals, and the area commission on aging to assess the need for services to patients with Alzhiemer's disease. During her investigation, she discovered that many persons with Alzheimer's disease rarely come into contact with professionals after the initial diagnosis is made. Although it was unclear why the care givers seemed to disengage, June suspected it was due to the despair many felt about treating persons with Alzheimer's disease. June's enthusiasm soon sparked enough interest among her contacts that a task force was set up to investigate the problem on a community basis.

Task Force or Forced Task?

June hoped that the task force would appreciate the emotional, social, and financial stresses that families face in dealing with long-term debilitating illness. Who should she invite to serve on it? She was aware that not all the members of the task force would share her enthusiasm for Alzheimer's victims. She would have to be well prepared when the task force convened. What kind of demographic data was needed? What services are available at present? How can new proposals be realistically funded? She had one week to plan her strategy, to discover those who were most likely to help, and to anticipate objections. She thought that education was the key to community involvement on behalf of Alzheimer's victims, but what were the most effective means of educating the public? June knew she must temper her enthusiasm and thoroughly educate herself in the days ahead. The quality of her own preparation and knowledge of the issues might make or break the project.

* * *

Authorship of Vignette: Ann Rice & Charlotte Syran

Source: R.L. Schneider, T. Decker, J. Freeman, L. Messerschmidt, C. Syran, eds. Specialized Course Outlines for Gerontological Social Work Education. Washington, DC: Council on Social Work Education, 1984.

APPENDIX E

The Collett/Lester Fear of Death Scale

Part III -- Here is a series of general statements. You are to indicate how much you agree or disagree with them. Record your opinion by circling the response at the end of each item according to the following scale:

+1 = Slight agreement
+2 = Moderate agreement
+3 = Strong agreement

-1 = Slight disagreement
-2 = Moderate disagreement
-3 = Strong disagreement

Read each item and decide quickly how you feel about it, then record the extent of your agreement or disagreement. Put down your first impression. Please answer every item.

1.	I would avoid death at all costs.	+3	+2	+1	-1	-2	-3
2.	I would experience a great loss if someone close to me died.	+3	+2	+1	-1	-2	-3
3.	I would not feel anxious in the presence of someone I knew was dying.	+3	+2	+1	-1	-2	-3
4.	The total isolation of death frightens me.	+3	+2	+1	-1	-2	-3
5.	I am disturbed by the physical degeneration involved in a slow death.	+3	+2	+1	-1	-2	-3
6.	I would not mind dying young.	+3	+2	+1	-1	-2	-3
7.	I accept the death of others as the end of their life on earth.	+3	+2	+1	-1	-2	-3
8.	I would not mind visiting a senile friend.	+3	+2	+1	-1	-2	-3
9.	I would easily adjust after the death of someone close to me.	+3	+2	+1	-1	-2	-3
10.	If I had a choice as to whether or not a friend should be informed he/she is dying I would tell him/her.	+3	+2	+1	-1	-2	-3
11.	I would avoid a friend who was dying.	+3	+2	+1	-1	-2	-3
12.	Dying might be an interesting experience.	+3	+2	+1	-1	-2	-3

13. I would like to be able to communicate with the spirit of a friend who has died. +3 +2 +1 -1 -2 -3

14. I view death as a release from earthly suffering. +3 +2 +1 -1 -2 -3

15. The pain involved in dying frightens me. +3 +2 +1 -1 -2 -3

16. I would want to know if a friend were dying. +3 +2 +1 -1 -2 -3

17. I am disturbed by the shortness of life. +3 +2 +1 -1 -2 -3

18. I would not mind having to identify the corpse of someone I knew. +3 +2 +1 -1 -2 -3

19. I would never get over the death of someone close to me. +3 +2 +1 -1 -2 -3

20. The feeling that I might be missing out on so much after I die bothers me. +3 +2 +1 -1 -2 -3

21. I do not think of dead people as having existence of some kind. +3 +2 +1 -1 -2 -3

22. I would feel uneasy if someone talked to me about the approaching death of a common friend. +3 +2 +1 -1 -2 -3

23. Not knowing what it feels like to be dead does not bother me. +3 +2 +1 -1 -2 -3

24. If I had a fatal disease, I would like to be told. +3 +2 +1 -1 -2 -3

25. I would visit a friend on his/her death bed. +3 +2 +1 -1 -2 -3

26. The idea of never thinking or experiencing again after I die does not bother me. +3 +2 +1 -1 -2 -3

27. If someone close to me died, I would miss him/her very much. +3 +2 +1 -1 -2 -3

28. I am not disturbed by death being the end of life as I know it. +3 +2 +1 -1 -2 -3

29. I would feel anxious if someone who was dying talked to me about it. +3 +2 +1 -1 -2 -3

30. The intellectual degeneration of old age disturbs me. +3 +2 +1 -1 -2 -3

31. If a friend were dying, I would not want to be told. +3 +2 +1 -1 -2 -3

32. I could not accept the finality of the death of a friend. +3 +2 +1 -1 -2 -3

33. It would upset me to have to see someone who was dead. +3 +2 +1 -1 -2 -3

34. If I knew a friend were dying, I would not know what to say to him/her. +3 +2 +1 -1 -2 -3

35. I would not like to see the physical degeneration of a friend who was dying. +3 +2 +1 -1 -2 -3

36. I am disturbed by the thought that my abilities will be limited while I lie dying. +3 +2 +1 -1 -2 -3

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VALUES AND ETHICAL ISSUES IN WORKING WITH THE AGED AND THEIR FAMILIES

This module is designed to enhance trainees' understanding of the ethical issues inherent in professional practice with the aged. Day-to-day professional decisions may be affected by a variety of factors ranging from an individual's personal belief system to broader societal attitudes. The place of professional ethics is explored within this context.

Presented in this module is training content on the following areas:

- Ethics as a social product;
- The societal context in which ethical decisions are made in the provision of human services;
- Select biomedical issues and related cases for discussion;
- Professional ethics related to practice in gerontology;
- Ethical issues that can arise in the practitioner-client encounter.

At the conclusion of this training participants will:

- Have increased awareness of the range of societal influences affecting ethical decision-making;
- Be able to articulate ethical issues in case planning with colleagues and other professionals;
- Understand their own belief systems;
- Identify their own ethical dilemmas.

Defining Ethics in Professional Practice

The goal of this unit is to define ethics within the context of multiple societal influences related to practice with the aged.

Definitions

> Values refer to a preferred or desired state of affairs. They are statements of how things should or ought to be. As such, they cannot be proven right or wrong, correct or incorrect. A value may or may not conform to how things exist in reality ... but to the way things would exist in our view of the best of all possible worlds (Simons and Aigner, 1985, p. 18).

Values are preferences: they are propositions about what is considered to be desirable. They indicate a "desirable mode of behavior or an end state that has a transcendental quality to it, guiding actions, attitudes, judgement and comparisons across specific objects and situations and beyond immediate goals to some ultimate goals." Values, translated into ethical principles, guide the practice of any profession (Northen, 1982, p. 27; Rokeach, 1973).

Ethics, in effect, are values in operation (Levy, 1976, p. 14).

Ethics is the science of moral duty or ideal human character (Webster's Dictionary, yr. 1976, pg. 299).

Ethics are the study of human actions in respect to their being right or wrong. The actions of individuals and social groups supply the subject matter of ethics (Encyclopaedia Britannica, yr. 1981, pg. 1265).

Professional ethics are the code by which a profession regulates actions and sets standards for its members. The professional code attempts to assure high standards of competence in a given field, strengthen the relationship among its members, and promote the welfare of the whole community (Encyclopaedia Britannica, yr. 1981, pg. 1265).

Professional ethics are a set of moral principles regarding a practitioner's conduct in the relationship with individuals, groups and organizations. An ethical principle sets forth what a practitioner is obliged to do under certain circumstances (Northern, 1982, pp. 29-30).

Discussion

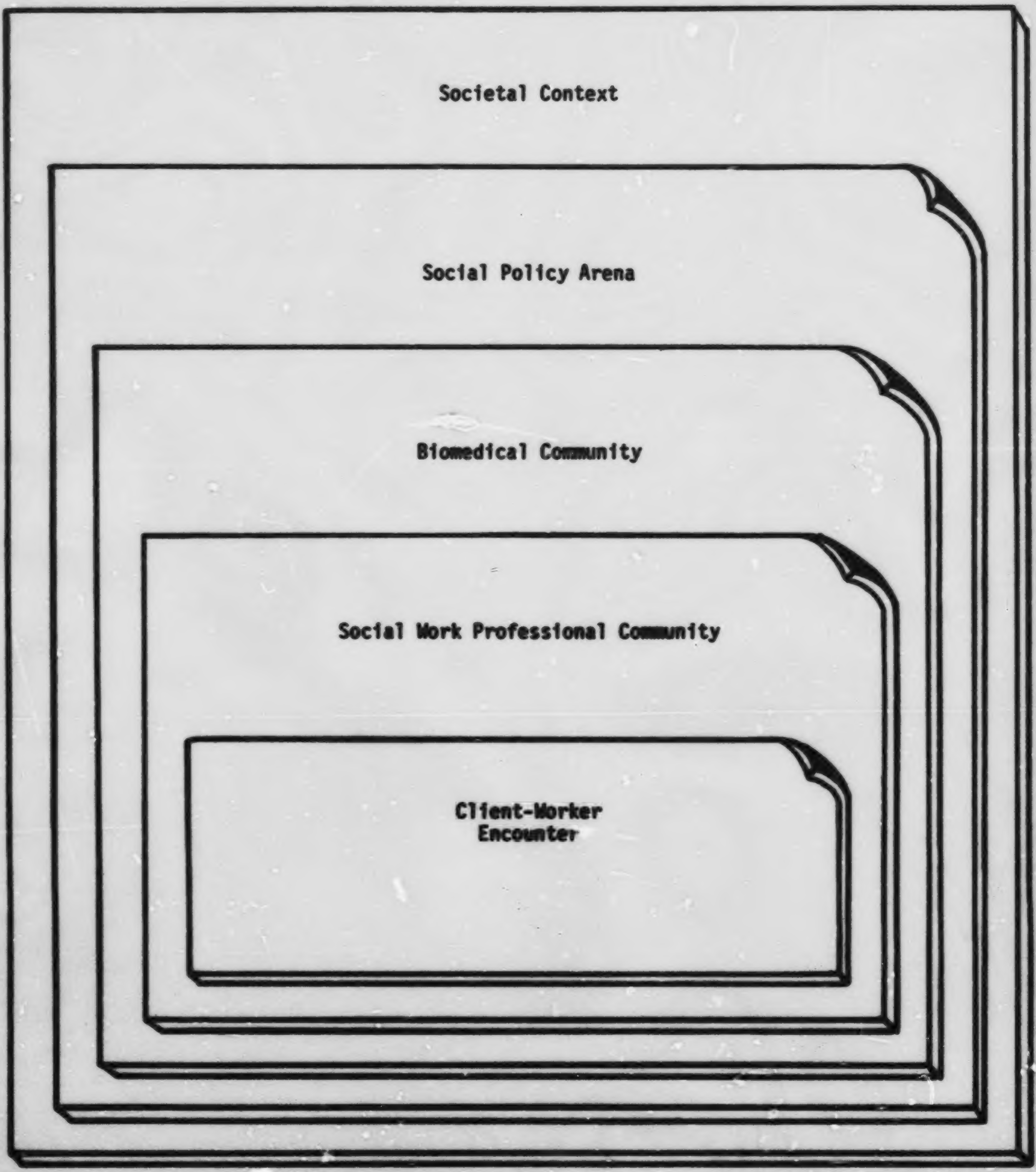
Ethics may be considered a social product which involves the obligatory actions of one party or group, and the rights of another (Levy, 1976, p. 27). To the extent that ethics rest upon "custom and habitual modes of conduct" (Webster's Dictionary, yr. 1976, pg. 299), they are a matter not only of personal values, but a reflection of societal influences.

From this perspective, ethical issues as they affect practice with the aged and their families must be addressed with regard to their societal import; professional ethical decisions must be made with consideration of the relative impact of broader social forces. Ethical issues may be discussed in general or related to specific issues such as ethics in discharge planning or long-term care (see Abramson, 1981; Moody, 1983). While trainers may focus on the specific ethical concerns of participants, it is important to place these concerns within the broader context suggested by the module to provide a general frame of reference.

Suggested Training Activities

This module explores some of the major factors affecting ethical decision-making in practice with the elderly. The graphic illustration on page two of this module provides a visual description of module content which can be used as a handout, drawn on the chalkboard or flipchart, or made into a transparency for projection on a screen. This illustration can be used to stimulate discussion of ethics in the client-practitioner encounter, in the professional community, in the biomedical community, in the social policy arena, and in a general societal context. This illustration also graphically depicts the interrelated and complex nature of ethics.

Graphic Presentation of Multiple-Layers of Influences on Ethical Decision-Making


Societal Context
Social Policy Arena
Biomedical Community
Social Work Professional Community
Client-Worker Encounter

Ethics in a Societal Context

Every society has a social structure that "comes into being through a set of ideas that define the rights and obligations of the position people occupy in groups" (Lowy, 1985, p. 48). Through this ongoing interactive proces, social order and social control are maintained by the community, and its network of values and goals is embodied in its social relationships and institutions (see Anderson and Carter, 1983). Consequently, in order to understand the ethical dilemmas which face the practitioner, it is first necessary to examine the borader societal context in which they take place.

While contemporary views on aging are complex and varied, reviews of American literature indicate that negative attitudes toward the elderly are widespread (McTavish, 1971; Butler, 1975, 1982). In our youth-oriented society, the image of an old person as weak, infirm, feeble, helpless and nonproductive is common. In fact, this view is so pervasive that the term "ageism" was coined to describe the prejudices and stereotypes that are applied to older people solely on the basis of their age (Butler, 1969). This prejudice toward old people, which is found to some degree in all of us, is

> a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender ... ageism allows the younger generations to see older people as different from themselves. Thus, they subtly cease to identify with their elders as human beings (Butler, 1975, p. 12).

Ageism is similar to other forms of prejudice, such as sexism and racism in that it pervades social institutions as well as individual belief systems, resulting in "triple jeopardy" for the older woman who is a minority group member (Dowd and Bengston, 1978; Sontag, 1972). Such stereotyping and discrimination in many areas such as employment, housing and medical care, can be widespread. In short, to the extent that the aged are not perceived of as valued members of society, they are much more likely to be treated inequitably.

Of particular importance to practitioners in gerontology is the fact that ageist attitudes have become professionalized (Coe, 1967; Garfinckel, 1975; Greene, 1983; Kalish, 1979). Butler (1982, p. 176) suggests that "in the mental health field, ageism has become professionalized--often to the point where it is not recognized"; Lowy (1985, p. 77) maintains that "social workers have inherited many of the myths of society and have made them part of their own value system"; Greene (1983) reports that even though social workers may elect to work with the aged, they nonetheless bring with them many stereotypes and fears of aging and death.

The same problem is found with other human service professionals. Such attitudes are often subtle and out of conscious awareness of the practitioner. Far too often, therapy with the aged is viewed "as only supportive," "a second-rate procedure," having "no systematic theory" or "not worth a long-term investment" (Butler, 1975; Cohen, 1976; Mutschler, 1971).

Sample Discussion Questions and Issues

In what ways is ageism reflected in our society; in our own beliefs; in the attitudes of those around us?

How do such ageist beliefs and attitudes affect social policies; the nature of social programs; and treatment approaches?

Participants can be asked from their own experience to provide examples of situations in which elderly women suffer "triple jeopardy."

Suggested Training Activities

Training participants can be asked to think about the first word, image, or idea that comes to mind when they hear the words "old age," and asked to share these with the group. These words, images, ideas, etc. can then be written down on a chalkboard or a flipchart and categorized and discussed by the group.

Training participants can be asked to think of all the people they know who do not fit the negative stereotypes of "old age."

In order to encourage and assist participants to explore their own value system, time should be allowed for the following exercises contained in the appendices to the module.

- Guide for an Autobiography (Appendix C)
- Facts on Aging - A Short Quiz (Appendix D)
- "Old People" Items (Appendix E)

Ethics in the Social Policy Arena

Ethics in the social policy arena relate to the design and implementation of programs and services and involve the recognition of entitlements or benefits. Some of the most persistent questions involving human services are "criteria for distributing scarce or limited resources, welfare rights, and the role of the state in the provision of social welfare" (Reamer, 1983, p. 32).

Ethical decisions in social policy are made by various professionals at a number of different levels including federal and state legislators, state and local welfare officers, and practitioners involved in the day-to-day delivery of human services. For example, Reamer (1983) proposes that social workers frequently make decisions about how to allocate scarce resources when providing certain clients with social service funds, equipment, bed space, time and personnel; while Moody (1982) maintains that social workers in long-term care are bound to be involved in "policy" when they invariably face questions related to home-health versus nursing home care. (See Module 10 for a fuller discussion of social policy issues.)

Sample Discussion Questions and Issues

Workshop participants should be encouraged to explore how their day-to-day practice and the practice of other professionals is related to the policy arena.

Trainees can be asked to identify current federal and state legislation and regulation that impacts service delivery to the elderly.

How does agency policy affect what the trainees can and cannot do in providing services to their elderly clients?

Participants can be asked how they and their agencies make decisions regarding what services are provided and which clients receive what services.

Ethics In the Biomedical Community

Professionals who work with the aged frequently encounter health-related problems, and often interact with the medical community. Consequently, they may be faced with ethical decisions involving biomedical issues. The goal of this unit is to present an overview of some of the major ethical and legal problems in medicine and biomedical research, including the definition of death, informed consent, availability of health care, and life-sustaining treatment.

Chronic illness increases with age, and an estimated 85 percent of the older population have one or more chronic conditions. Many human service workers practice in hospitals, nursing homes, and other health settings where they provide services to the chronically and acutely ill as well as the terminal patient. They also consult with families and physicians about the psychosocial aspects of medical problems. As a result, there is a growing interest in and concern among practitioners about a number of bioethical issues:

> Who will live and who will die? Who decides, on what grounds? Are there certain characteristics--when "defining" life or setting the boundries of permissible genetic experimentation--that are essential for "humanness"? In distributing risks and benefits, when should choices be left to the consciences of individuals and when should they be constrained collectively--by expert or lay groups, legislators, administrators, or judges? (President's Commission for the Study of Ethical Problems, March 1983).

In November 1978 the U.S. Congress authorized the creation of a Presidential Commission with continuing responsibility to study and report on such ethical and legal issues in medicine and research. In the course of their work, the Commission heard testimony from more than 300 witnesses including physicians, biologists, lawyers, clergymen, political and social scientists, members of the insurance industry, members of the public, including health care consumers, and professional groups such as the American Psychological Association. Their mandate was "to bring ethical analysis to the implications of medical practice and research out of the classrooms, the hospital wards, and the scholarly journals and into a public forum in Washington" (President's Commission, 1983).

The issues raised and the recommendations made by the Commission were discussed in five reports related to the provision of health care, and in four studies focused in biomedical and behavioral research. The Commission also authored an Official Institutional Review Board Guide Book. Collectively, these reports encompass the major contemporary biomedical ethical questions, and raise many issues pertinent to gerontological practice. The following is a brief description of the health-related reports.

The Definition of Death

The first question posed by the President's Commission was whether the law ought to recognize a new means for "officially" establishing that death has occurred. This was thought to be necessary because of the confusion brought about by medical technology; it is now possible to keep an individual's heart and lungs functioning when his/her brain may not be. A dilemma is posed by the fact that this technology may also keep heart and lungs functioning in persons less severely injured, thus making it difficult to distinguish between patients who are dead, and those who are dying or severely injured.

The Commission concluded that recent developments in medical treatment necessitate a restatement of the standards traditionally recognized for determining death, and that such a restatement should be a matter of state statutory law, with uniformity among the states. The statute they suggested proposes that:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory function, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards (Presidents' Commission, 1983, p. 16).

Because the Commission concluded that "defining" death should be a matter for the various state legislatures, it has been up to each state's health and judiciary subcommittees to coordinate state activities in this direction.

Life-Sustaining Treatment

> Virtually all people who die in this country will have been under treatment by health care professionals who have, especially in the last four decades, developed powerful means to forestall death.... Physicians realize, of course, that the mission of vanquishing death is finally futile, but often they and their patients are quite determined to do all that is possible to postpone the event. Sometimes this objective so dominates care that patients undergo therapies whose effects do not actually advance their own goals and values. Specifically, the drive to sustain life can conflict with another fundamental (and arguably more venerable) objective of medicine--the relief or suffering.... The attempt to postpone death should at times yield to other, more important goals of patients (Deciding to Forego Life-Sustaining Treatment, 1983, pp. 15-16).

In its study of the "definition" of death, the Commission was struck with the "depth of public concern about life-sustaining treatment of patients who are dying or permanently unconscious." As the Commissioners became aware that "conflicting values between physicians and patients, between patients and their families, or among family members are not uncommon," they decided it would be valuable "to clarify the rights, duties, and liabilities of all concerned" (Summing Up, 1983, pp. 31-32).

The Commissioners' conclusions are numerous and complex, emphasizing the following themes:

- Respecting the choices of individuals competent to decide to forego even life-sustaining treatment;
- Providing mechanisms and guidelines for decision-making on behalf of patients unable to do son on their own;
- Maintaining a presumption in favor of sustained life;
- Improving the medical options available to dying patients;
- Providing respectful, responsive, and supportive care to patients for whom no further medical therapies are available or elected; and
- Encourageing health care institutions to take responsibility for ensuring that adequate procedures for decision-making are available for all patients (Deciding to Forego Life-Sustaining Treatment, 1983).

Informed Consent for Making Health Care Decisions

> The complexities of modern life make it difficult for individuals to be masters of their own fate. Perhaps in no sphere of everyday activity is this more acute than in health care.... Traditionally, many cultures, including this one, have responded by according healers a unique deference and authority in their relationships with patients. Yet this authority is not and has not been absolute.... American courts, supported by legal and ethical commentary, have articulated a legal docutrine of "informed consent" that requires health care practitioners not simply to seek the consent of their patients, but also, through a process of disclosure and discussion between practitioners and patients, to make such consent "informed" (Making Health Care Decisions, October 1982, pp. 15-16).

The Commission focused its report Health Care Decisions (1982) on informed consent in medical treatment and examined the relationship between patients and health care providers. This included an exploration of the way in which informed consent (1) promoted communication between patients and health care professionals, (2) contributed to more autonomous decisions by patients, and (3) improved therapeutic outcomes by increasing patient trust.

In order to learn more about informed consent, the Commission held hearings, contracted for three empirical studies, which observed and recorded actual interactions between patient and professionals, and also arranged for a Harris Poll. "The results showed that the public and physicians agree that patients have a right to all available information regarding their condition and treatments and that the public universally desires such information" (Summing Up, 1983, p. 18).

The Commission concluded that although the principle of informed consent has substantial foundations in law, it is essentially an ethical imperative to encourage decision-making based upon mutual respect and participation. The Commission also maintained that competent individuals are entitled to make their own health care decisions based upon personal values and goals.

Differences in the Availability of Health Care

> In 1980, the nation spent an estimated $247 billion on health care--an average of more than $1,000 for every citizen. Yet despite this enormous investment, all Americans do not share equally in the benefits of the health care system. Testimony presented to the Commission indicates that certain groups--the poor, minorities, the uninsured, and residents of inner-city and rural areas--are more likely to receive inadequate health services. Although most would agree that society has an ethical obligation to secure some level of care for those in need, past governmental programs and pronouncements by public officials do not reveal a consensus as to the level and nature of this commitment (Summing Up, 1983, p. 27).

This statement reflects the concern of the Commission of Securing Access to Health Care about the ethical implications of differential access to medical services. During their meetings, the Commissioners explored a number of philosophical issues, including the right to health care, the concept of adequate care, and the principle of the patient's freedom of choice. In addition, they held hearings during which testimony was presented by: (1) members of the public who had found it difficult to obtain and pay for health services, (2) physicians and hospital administrators who had experienced problems in the delivery of health care to the poor, and (3) health officials and heads of voluntary organizations who were knowledgeable about access patterns and policies in their states.

While the Commission did not propose any new policy initiates, it did provide a framework for debating health policy issues, and it did come to the following conclusions:

(1) Society has an ethical obligation to ensure equitable access to health care for all.

(2) The societal obligation is balanced by individual obligations:

> Individuals ought to pay a fair share of the cost of their own health care, and take reasonable steps to provide for such care when they can do so without excessive burdens.

(3) Equitable access to health care requires that all citizens be able to secure an adequate level of care without excessive burdens:

> ...Equitable access also means that the burdens borne by individuals in obtaining adequate care (the financial impact, travel, etc.) ought not to be excessive or to fall disporportionately on particular individuals.

(4) When equity occurs through the operation of private forces, there is no need for government involvement, but the ultimate responsibility for ensuring that society's obligation is met, through a combination of public and private sector arrangments, rests with the Federal Government.

(5) The cost of achieving equitable access to health care ought to be shared fairly.

(6) Efforts to contain rising health care costs are important but should not focus on limiting the attainment of equitable access for the least well served portion of the public (Summing Up, 1983, pp. 29-30).

Sample Discussion Questions and Issues

It is suggested that a description of each report be followed by discussion questions and case examples. Cases are provided in Appendix A to this module, and can also be obtained from training participants. Newspaper articles on related topics can also be used for discussion. Sample articles are provided in Appendix F, but it is recommended that trainers obtain recent articles on current issues.

The "Policy Guielines for Treatment Orders at the End of Life," contained in Appendix B, can be used to further discussion.

Trainers may wish to ascertain the status of legislation in their jurisdiction, and raise questions for discussion.

What are the implications of the Commission's recommendations? How realistic are the recommendations in light of current policy trends?

How does the principle of informed consent apply to practice with the elderly? Is it always feasible to apply the principle of informed consent? Are there alternatives to obtaining informed consent?

Participants can be asked to apply the principle of informed consent to an 81-year-old woman suffering from senile demential, for whom a risky medical diagnostic procedure has been recommended. The woman has outlived her husband and has no children or other relatives. She had not made a living will.

Participants can be asked to describe the way in which health care is allocated in their geographical area.

Participants can be encouraged to formulate suggestions for data collection, research and policy initiatives.

As more and more practitioners are serving on institutional review boards, participants who practice in nursing homes, hospitals and other health-related settings mey wish to share how decisions to forego treatment are made at their institution.

Participants should be given the opportunity to discuss the themes underlying the Commission's conclusions as they pertain to their own specific responsibility.

Ethics in the Professional Community

All professional groups establish their domain through societal authority and sanction and on a foundation of values. These values, which are often incorporated into codes or policy statements, "provide the profession with its goals and thereby direct the activity of its members" (Simons and Aigner, 1985). This means that social work, as with other occupations, must establish its professional claim, and be recognized by society "as responsible for a symbolic territory" (Anderson and Carter, 1984). As part of this process a domain of specialized knowledge must be developed to provide the theoretical base for practice and by which the profession expresses its function (Brehm, 1965, p. 641).

The discussion of professional ethics in this section will focus on the ethical base of the social work profession. Social work has been an established profession in this country for almost one hundred years. During that time social work has not deviated much from the values out of which it first grew--respect for the individual, the right to human dignity and self determination--but rather built on to that foundation of values, and over the years clarified and formalized the values and ethics of the profession in the National Association of Social Workers' "Code of Ethics." A list of national organizations from which codes of ethics for other professions in the human services can be obtained is provided in Appendix G.

Ethics in Social Work

> Social work is the professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and create societal conditions favorable to their goals (National Association of Social Workers, 1973, pp. 4-5).
>
> Social work focuses on the transactions between people and their environments that affect their ability to accomplish life tasks, alleviate distress, and realize individual and collective aspirations (Council on Social Work Education, 1982, Curriculum Policy for Social Work Education, p. 3).

Levy (1976, pp. 106-108) suggests that social work ethics, which are an idealization of professional conduct, serve three essential purposes: they are a guide to professional conduct, a set of principles that social workers can apply in the performance of the social work function, and are a set of criteria by which social work practice can be evaluated. In short, social work ethics, which represent a "system of control," alert the social worker to those considerations that must be evaluated before making a professional decision or choice.

The ethical choices that social workers encounter have been placed into three broad classes: direct service to individuals and families, design and implementation of social welfare policy and programs, and relationships among professional colleagues (Abramsom and Reamer, 1982; Reamer, 1983). The NASW Code of Ethics (1979) is intended to serve as a guide in this endeavor, and represents standards of ethical behavior "associated with an individual's status and identity as a social worker" (Preamble, NASW Code, 1979, see appendix). While a professional code of ethics may serve as a guide, it cannot possibly resolve the conflicts and ambiguities of every situation.

Ethics in the Social Worker-Client Encounter

> The interview begins before it starts. It begins before the two participants meet, in their thoughts and feelings as they move toward the actual encounter (Kadushin, 1972, p. 106).

While professional knowledge and skill generally suggest what takes place in an interview, Kadushin (1972) points out that both the client and the practitioner bring "a configuration of determinants" to the social work encounter: just as the client brings to the interview his/her reference group affiliations, his/her primary group affiliations and his/her biopsychosocial history and current functioning, so too does the social worker (pp. 61-67). This means that no matter how competent the practitioner, his/her own values and beliefs come into play in the delivery of social work services.

> The interviewer's belief system comprises expectations that predispose her to "hear" certain responses.... We think in categories and expect a person to behave in some consistent manner according to the pigeonhole to which we have assigned him.... We attribute to individuals the attributes of the groups with which we preceive them to be affiliated...(Kadushin, 1972, p. 33).

The personal belief system of the practitioner is a reflection of his/her cultural heritage. It grows out of the socialization process of which professional education is a part. There will be times when one's personal beliefs conflict with or may even override the professional. At times, this can pose ethical dilemmas. Although Kadushin is a social worker and wrote regarding social work practice, his words can be applied to all professions involved with the provision of human services.

Sample Discussion Questions and Issues

In reviewing the materials in this section of the module, the trainer may wish to select a particular ethical issue for discussion. For example, a protective service case is one that has much significance for practice with the aged and could be discussed during this unit (Appendix A contains an adult protective service case). Because such situations involve questions of the client's right to freedom versus the professional's responsibility to intervene, they often pose many ethical questions which workshop participants can be asked to discuss.

Trainers may want to relate the discussion directly to the code(s) of ethics of the professional affiliations of the training participants. A list of professional organizations from which codes of ethics can be obtained is provided in Appendix G. Copies of ethical codes can be obtained from these organizations at minimal cost.

Summary of Practice Implications

Professional ethics are the code by which a profession regulates actions and sets standards for its members. As a guide to practice, however, such codes do not offer specfic directions. For example, the practitioner can be faced with many ethical dilemmas as s/he attempts to assure the client the right to self-determination: the frail client who fires "a much needed" homemaker, the family who makes a decision for the older person "because it is best," or the client who "must be placed in a nursing home for his/her own safty" are situations which can create value conflicts for the practitioner. Ethical decisions are most difficult to make when there seems to be no clear-cut answer or overriding sense of "right" or "wrong."

Sample Discussion Questions and Issues

Trainees can be provided with the Code of Ethics of several professions involved in the provision of human services and a comparison of the Codes can be made for similarities, differences and potential conflicts among them can be made.

Workshop participants may be asked to address the question of how their personal beliefs about the use of "heroic measures" might affect their practice.

An important aspect of this training is learning how other professionals handle certain ethical decisions. Participants should be given the opportunity to discuss cases and exchange ideas about ethical decisions. Also for discussion, cases are provided in Appendix A to this module.

Abramson, M. "Ethical Dilemmas for Social Workers in Discharge Planning." Social Work in Health Care, 6, 4 (Summer 1981), 33-42.

This paper examines the conflicting values inherent in the discharge planning process. The necessity to work with mandated and state regulations aimed at cost containment and quality care assurance requires that "the hospital social service departments must plan and provide whatever social services are necessary to guarantee that the patient is medically ready to leave the hospital." The author asks what the significance of this emphasis is for the social worker whose code of ethics states that "the social worker's primary responsibility is to the client." This question is reviewed within the context of self-determination, "doing good," the patients' bill of rights, and a framework for analyzing ethical dilemmas. Case examples are also given.

__________. "Ethical Issues in Social Work Practice with Dying Persons." In L.H. Suzychi, M.Abramson, et al., eds. Social Work and Terminal Care. New York: Praeger, 1984.

Social work practice with dying persons is an area of social work's specialization that presents significant and difficult ethical dilemmas. The purpose of this chapter is to examine three areas of ethical conflict that social workers confront in working with dying patients and their families: client autonomy versus social work paternalism; truth telling; and value conflicts in interdisciplinary collaboration. The use of the case example to illustrate these dilemmas is particularly useful.

__________. "Model for Organizing an Ethical Analysis of the Discharge Planning Process." Social Work in Health Care, 9, 1 (Fall 1983), 45-52.

This paper presents a model for identifying, clarifying and analyzing the ethical dilemmas inherent in the discharge planning process of the chronically impaired older person from an acute-care hospital to the community or an institution. The author selects two categories of questions to address. The first concerns the conflict between provider paternalism and client autonomy. The second question involves distributive justice and the allocation of scarce resources. Two cases are examined in order to identify the morally relevant facts, personal alternatives and competing values, and ethical principles. This article, which really makes the issues come alive, is a must for anyone involved in geriatric services.

__________. "Social Work and the Safty Net." Hasting Center Report Institute of Society, Ethics and the Life Sciences, 1982.

This article examines two views of social welfare, the residual and the institutional, as they relate to ethical decisions in social work practice in the health and mental health settings. Cases are presented which raise questions of autonomy, paternalism, social control, and/or confidentiality.

Bell, W.G.., Schmidt, W., and Miller, K. "Public Guardianship and the Elderly: Findings from a National Study." The Gerontologist, 21, 2 (1981), 194-202.

The basic question in this research is: to what extent do current provisions in state public guardianship laws assist or hinder elderly persons in attaining their individual rights, benefits, and entitlements? A review of statutes in 34 states including on-site visits led the author to conclude that the continuation of public guardianship is necessary if less restrictive alternatives are developed and adult protective services strengthened. A model statute on public guardianship is proposed.

Besdine, R.W. "Decisions to Withhold Treatment from Nursing Home Residents." Journal of the American Geriatrics Society, 31, 10 (1983), 602-605.

Most decisions to withhold treatment in the nursing home emerge in the following three categories: do not resuscitate, (DNR); do not hospitalize (DNH); and do not treat (DNT). The author suggests that implementing these decisions to restrict treatment in a nursing home has features that differ from the hospital process because of the type of caregiving and ethical dilemmas of the caregivers. These issues are compounded when residents are not alert and the deterioration in condition is ongoing. Establishing an ethical issues team is seen as an important vehicle to solving such problems.

Buchanan, A.E. "Limitations on the Family's Right to Decide." In R.E. Cranford and A.E. Doudera, eds. Institutional Ethics Committees and Health Care Decision Making. Ann Arbor, MI: Health Administration Press, 1984.

This article outlines three models of decision-making for incompetent patients: (1) "medical paternalism" referred to as "the view that it is essential to the physician's role to be primary decision-maker"; (2) "legal imperialism," seen as the view that the judge or makers of administrative law should act as the primary decision-maker; and (3) the family autonomy model which argues that the family is the appropriate decision-maker and should act on the patient's behalf. The author reviews and comments on each model and suggests that there is a major role for an institutional ethics committee in decision-making.

Callahan, D. "On Feeding the Dying." The Hastings Center Report, October 1983, p. 22.

This essay discusses the moral and ethical issue of whether feeding the brain dead patient such as Karen Ann Quinlan is "(a) no more than a prolongation of her dying, (b) morally no different an act than the long-since discontinued artificial respiration, and (c) costly to society." The author concludes that feeding of hungry is such a fundamental human relationship that discontinuation of feeding should generally not be considered. "No doubt some people will live on in ways beneficial neither to them nor to others. No doubt a good bit of money will be wasted indulging rationally hard-to-defend antistarvation policies. That strikes me as a tolerable price to pay to preserve--with ample margin to spare--one of the few moral emotions that could just as easily be called a necessary social instinct" (p. 22).

Cranford, R. E., and Doudera, A.E., eds. Institutional Ethics Committees and Health Care Decision Making. Ann Arbor, MI: Health Administration Press, 1984.

This book is a compilation of articles on ethics as they relate to institutional settings. It includes articles on institutional ethics committees, patients' attitudes toward Hospital Ethics Committees, the decision to withdraw life-sustaining treatment, and the limitations on the family's right to decide for the incompetent patient.

Ehrlich, I.F., and Ehrlich, P. "Social Work and Legal Education: Can They Unite To Serve the Elderly?" Journal of Education for Social Work, 15, 2 (Spring 1979), 87-93.

In this paper the authors report on a research, training and demonstration study that dealt with the interaction of law and social work graduate students in delivering services to the elderly poor. They report on other joint programs, the attitudes of the professional groups involved and the implications for professional higher education.

Ehrlich, P. "Elderly Health Advocacy Group: An Integrative Planning Model of Elderly Consumers and Service Deliverers." The Gerontologist, 23, 6 (1983), 569-572.

"Unfortunately, many elderly accept the status quo of medical care delivery, and health professionals tend to exclude them from both the community process and policy issues." This paper suggests an innovative group structure and process for integrating health care providers and elderly consumers in community health care planning, implementation, and evaluation. The Elderly Health Advocacy Group, which involves elderly consumers and service providers as collaborative participants in a "consensus model," is described and its developmental processes outlined (see also Ehrlich, P. Elderly Health Advocacy Group: Handbook of Organizing Principles. Springfield, IL: Department of Public Health, 1980).

Gadow, S. "Medicine, Ethics, and the Elderly." The Gerontologist, 20, 6 (1980), 680-685.

The author uses three case examples to illustrate how contemporary views of aging, coupled with the valuation of the older person by the medical practitioner, can present ethical problems in health care. She suggests that contemporary views within the health field are that (1) aging is the antithesis of health and vigor; (2) aging is an unwelcome reminder of our mortality; (3) the elderly are underprivileged or oppressed; and (4) aging is a "clinical entity in its own right" (p. 681).

German, P.S., Shapiro,.S., Chase, G.A., and Vollmer, M.A. "Health Care of the Elderly in Medically Disadvantaged Populations." The Gerontologist, 18 6 (1978), 547-555.

This study of three "disadvantaged" urban areas (East Baltimore, surrounding Johns Hopkins and predominantly black; Southeast Baltimore, an industrial area of mostly white blue collar workers; and Lower Park Heights-Pimlico, an area of racial transition and new HMOs) reports on the relationship between available resources and ambulatory care. Findings indicate a high proportion receiving care for serious conditions except for a group of elderly receiving care through a new Health Maintenance Organization. In a community of recent socioeconomic transition, there was evidence that isolated elderly turn to medical-care resources for other than health reasons.

Gibson, D.E. "Hospice: Morality and Economics." The Gerontologist, 24, 1 (1984), 4-15.

This article examines hospice concepts. Proposals are examined in order to identify moral problems presented by this "new" direction in health care. Particular attention is given to "the relationship between the hospice concept's alleged humanitarian superiority and the emphasis on cost efficiency present in much of the hospice literature and in recent Congressional legislation." The author believes this emphasis on cost raises serious questions about the meaning of hospice concepts for the well-being of patients, society's valuation of life, and medical ethics, e.g., the right to die and euthanasia (p. 4).

Jankovic, J., and Green, R. "Teaching legal principles to Social Workers." Journal of Eduction for Social Work, 17, 3 (Fall 1981), 28-35.

This article examines the historical interaction between law and social work, current legal principles necessary for practice, and their implications for social work education. The author identifies seven areas basic to all of social work practice: confidentiality, client consent to social work intervention, understanding legal rights of parents and children, evaluation and documentation of evidence in a case record, using legal authority of one's position as a base for practice, giving substantive factual testimony in a court hearing, and legal duties implicit in professional practice.

Jonas, H. "Philosophical Reflections on Experimentling with Human Subjects." In T. Shannon, ed., Bioethics. New Jersey: Paulist Press, 1976, pp. 235-261.

Jonas' article provides a comprehensive review of fundamental ethical issues in human experimentation. The major issue at the heart of the experimentation debate, namely the polarity between the individual and society, is discussed and specific resolutions are offered.

Joseph, M., and Conrad, A.P. "Teaching Social Work Ethics for Contemporary Practice: An Effectiveness Evaluation." Journal of Education for Social Work, 19, 3 (Fall 1983), p. 59-68.

This article presents an empirical study designed to compare the effectiveness of two models of teaching professional ethics at the master's level: the pervasive method--an integrated approach whereby ethical content is infused throughout the curriculum, and a discrete semester's course. The findings, which, of course, are relevant to continuing education as well, suggest that the pervasive model is not adequate for teaching systematic ethical analysis and decision-making.

Kart, C.S. "In the Matter of Earle Spring: Some Thoughts on One Court's Approach to Senility." The Gerontologist, 21, 4 (1981), 417-423

Recent court cases have raised important issues about the access of older people to life-prolonging medical treatments. In the case of Earle Spring, a senile patient suffering from chronic kidney failure, three Massachusetts courts (Probate, Appeals and Supreme) essentially ruled that "senility" is a sufficient basis upon which to terminate medical treatment. This article discusses the bases of the court decisions and highlights where the courts' approach is inconsistent with current gerontological understanding.

Kastenbaum, R. "On Death and Dying: Should We Have Mixed Feelings About our Ambivalence Toward the Aged?" Journal of Geriatric Psychiatry, 7, 11 (1974), 94-120.

This article is a classic in describing our ambivalence toward the aged, the dying and the dead. It takes a hard look at societal images of the aged and our conception of "natural death." It is followed by a discussion on death and dying by Don Lipsett in which he states that "the attitudinal pendulum seems to swing from gerontophobia to gerontophilia, from avoidance of death to preoccupation with it" (p. 108).

Levine, C., and Veatch, R. M., eds. Cases in Bioethics from the Hastings Center Report. Hastings-on-Hudson, NY: The Hastings Center, 1982.

This book is a "must" for anyone interested in bioethics. It provides a wide-ranging series of issues, each of which is followed by commentaries. Situations presented, which deal with specific "real life" events, range from issues of reproduction to those of death and dying. Patient-physician relationships, mental health and medical interventions, human subjects research, the allocation of scarce resources, and public policy are the other general topics covered. Articles (with commentaries) which may be of interest to professionals in gerontology include: "The Doctor, the Patient, and the DRG," "Family Wishes and Patient Autonomy," "A Demand to Die," "Studying Grief Without Consent," and "A Suicide Attempt (of a 68-year-old man) and Emergency Room Ethics."

Lynn, J.H. "Ethical Dilemma: Should Independence Outweigh a Patient's Safety?" Medical Economics, April 30, 1984, pp. 159-166.

This article discusses a doctor's dilemma: "The mother, who had substantial cognitive deficits, dreaded leaving the old neighborhood, but her daughter wanted her in a nursing home. The doctor was caught in the middle."

Maguire, D. "The Freedom to Die." In T. Shannon, ed. Bioethics. New Jersey: Paulist Press, 1976, pp. 209-218.

The author presents a discussion of whether it is appropriate to actively intervene to achieve death by choice or whether it is necessary to wait for nature to take its course. Four situations are examined: (1) the irreversibly comatose patient artifically sustained; (2) the conscious patient with a terminal illness supported by natural means; (3) the conscious patient artifically supported; and (4) suicide in a nonmedical context.

Monk, A., and Abramson, M. "Older People." In S.A. Yelaja, ed. Ethical Issues in Social Work: Practice With Older People. Springfield, IL: Charles C. Thomas, 1982.

The authors of this book chapter outline a number of ethical issues which are particularly relevant to social work practice with the older adult. They first discuss the utilitarian perspective by which older persons are stereotypically viewed as obsolete and outliving their usefulness. Other problems addressed are equity and the young-old, autonomy and dependence, rights versus needs, and families and the institutionalization dilemma.

Moody, H. R. "Ethical Dilemmas in Long-Term Care." Journal of Gerontological Social Work, 5, 1/2 (1982), 97-111.

The author suggests that social workers practicing in long-term care for the elderly--both in nursing homes and in home-health care settings--will invariably confront certain ethical dilemmas. These include: (1) confronting the systematic mislabeling of clients to help them qualify for services; (2) deciding how to deal with abuse, neglect and mistreatment of (nursing home) patients; (3) dealing with restrictions in nursing home admissions according to race, religion or prior/current monetary contribution; (4) deciding if it is proper to receive gifts from patients or their families; and (5) deciding whether to encourage a patient to use a treatment or participate in research. He suggests ethical theories which point to solutions.

Outka, G. "Social Justice and Equal Access to Health Care." In T. Shannon, ed., Bioethics. New Jersey: Paulist Press, 1976.

This article provides a good introduction to the topic of how to allocate scarce resources. The author considers a variety of means of distribution based on different concepts of social justice: (1) to each according to his merit or desert; (2) to each according to his societal contribution; (3) to each according to his contribution in satisfying whtever is freely desired by others in the open market place of supply and demand; (4) to each according to his needs; and (5) similar treatment for similar cases.

Pressey, S. "Comment: Any Rights As To My Dying." In S. Tobin, ed. Current Gerontology: Long-Term Care.

This is a personal statement by Dr. Pressey, a gerontologist, made when he was 88 years of age and "living in a residency for the old." He looks back at 60 years as a gerontologist and asks questions about public opinion, the law and the right to die. He states: "At the age of 88, crippled by rheumatism, plagued by insomnia, of failing vision, must I wait out a 'natural' death--perhaps becoming mindless, incontinent, locked in a back ward of a nursing 'home'? Do I have any rights as to the time and nature of my dying?"

Ratzan, R.M. "The Experiment That Wasn't: A Case Report in Clinical Geriatric Research." The Gerontologist, 21, 3 (1981), 297-302.

This paper attempts to relate the detailed history of a failed clinical experiment to evaluate sweat patches for the stimulation of digoxin levels in institutionalized patients. Of the 312 patients in the home, 11 fulfilled criteria for participation in the study. However, they refused to participate for reasons of comfort and/or fear. The author discusses the implications of this case with special reference to the method of review by the institutional review board and the role of the private physician in advising the potential subject(s).

Reamer, F. "Ethical Dilemmas in Social Work Practice." Social Work, 28, 1 (January-February 1983), 31-35.

This article discusses three broad categories in which there may be ethical dilemmas in social work practice: direct service to individuals and families, design and implementation of social welfare policy and programs and relationships among professional colleagues. It also presents a series of guidelines for assessing cases in which standard social work values come into conflict. For example, the author asks how social workers make decisions about how to distribute limited or scarce resources, including social service funds, equipment, personnel, bed space and time. He suggests that "the principle of need should guide the distribution of limited resources" (p. 34).

Reich, W. "Ethical Issues Related to Research Involving Elderly Subjects." The Gerontologist, 18 (1978), 326-337.

This article draws on ethical principles and general ethical rules governing discrete aspects of human research to identify and analyze the following problems distinctive to biomedical and behavioral research with aged subjects: (1) antiaging research; (2) health problems in the aged that make them vulnerable to excessive selection for research; (3) conditions of the elderly that create problems of competence and free consent to research; (4) surrogate consent and the problem of guardianship; and (5) special problems in competence and free consent for the institutionalized elderly. Policy recommendations governing research in the aged are offered as well as an agenda for an extensive research project in this area (p. 326).

Shannon, T. "The Withdrawal of Treatment: The Costs and Benefits of Guidelines." In T. Shannon, ed. Bioethics. New Jersey: Paulist Press, 1976, pp. 219-231.

Problems associated with the withdrawal of individuals from life support systems have caused numerous ethical and policy problems. This article reviews four sets of guidelines that have been issued by hospitals and medical associations.

Shanon, T., ed. Bioethics. New Jersey: Paulist Press, 1976.

This writer in bioethics presents a series of articles each with a specific ethical argument or position written from an interdisciplinary perspective. There are eight sections: abortion, severely handicapped children, death and dying, research and human experimentation, ethical dilemmas in obtaining informed consent, genetic engineering and genetic policy, the allocation of scarce resources; and behavior modification.

Siegler, M. "Should Age Be A Criterion in Health Care?" The Hastings Center Report, October 1984, pp. 24-27.

This article asks how scarce medical care resources should be allocated among the aged, the middle-aged, the slightly-aged, and the young. That is, when the care of the elderly imposes emotional and financial burdens on others--family, society, the middle-aged population--should the elderly be treated with less vigor for similar medical problems than, say, the middle-aged and the young? The author suggests that a decision should be made by taking into account a correct perception of the medical indications, an appreciation of the patient's values and preferences, an evaluation of the patient's quality of life and an awareness of external considerations such as the role of family and the cost of care.

Taub, H. "Informed Consent, Memory and Age." The Gerontologist, 20, 6 (1980), 686-690.

This article presents the results of a research study which examines the difficulties of elderly volunteers in providing informed consent. The author states that although young and elderly females signed appropriate consent documents as volunteers for research, most of the elderly answered multiple choice questions incorrectly when tested for information two to three weeks later. He proposes that to protect the rights of the elderly person with memory deficits or low levels of education, it may be necessary to use tests for comprehension before participation in research.

Veith, F.J. "Brain Death." In T. shannon, ed. Bioethics. New Jersey: Paulist press, 1976.

Many debates on brain death have occurred over the past decade. This has involved issues of medical technology which would allow circulation and respiration to be artificially maintained even though the brain is destroyed; other debates have focused on the use of a brain death definition so that organs can be harvested for transplantation; while others argue that a revised definition of brain death would ease dilemmas associated with turning off life support systems. This article summarizes the information on clinical and laboratory criteria for brain death, argues that the concept of brain death is in accord with the three major Western religions, shows the need for legislation in this area, and reviews the present status of the law.

Wershow, H. J. "Comment; Reality Orientation for Gerontologists: Some Thoughts About Senility." The Gerontologist, 17, 4 (1977), 297-302.

This frank, provocative article will demand much discussion. It suggests that "we accept the reality that brain cells, once destroyed, do not regenerate and "recognize that special institutions for the severely damaged senile dements require few mental-psychological therapies." The author also questions whether it is helpful to keep "senile" patients at home and asks if it is ethical to treat intercurrent infections. He asks, "Must we be bound to keep alive as long as possible those poor souls who sit tied into their chairs, babbling incoherently, doubly incontinent, whose dining consists of having usually cold food stoked into them as rapidly as possible by overworked aides who must move on and stoke the next bed's prisoner? Is this living, much less living with dignity?" (p. 301).

In rebuttal see: Cohen, G. "Comment: Organic Brain Syndrome Reality Orientation for Critics of Clinical Interventions." The Gerontologist, 18, 3 (1978), 313-314; Armstrong, P.W. "Comment: More Thoughts on Senility." The Gerontologist, 18, 3 (1978), 315-316.

Wright, R., Creecy, R.E., and Berg, W.E. "The Black Elderly and Their Use of Health Care Services.: Journal of Gerontological Social Work, 2, 1 (1979).

This study attempts to link, within a causal framework, predisposing, enabling, and need for care variables to the utilization of physicians' services by a low-income, black, aged population. The findings indicate that the measures of need for care are the most important determinants of physician utilization. Implications of the study for the development of health care policy and for research in the future are highlighted.

Yordi, C.L., Chu, A.S., Ross, K.M., and Wong, S.J. "Research and the Frail Elderly: Ethical and Methodological Issues in Controlled Experiments." The Gerontologist, 22, 1 (1982), 72-77.

This article raises and addresses a number of ethical and methodological issues related to research involving vulnerable populations such as the frail elderly, when the research design calls for a control or "nonintervention" group. In such studies, certain service needs of the control group cannot ethically be ignored. Techniques are presented for building a "limited" sevice component into the research design and an assessment is made of the methodological implications of employing the suggested techniques.

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AUDIOVISUAL RESOURCE

"The Right to Die." 16mm film/Color. 56 minutes, 1974. Available from: The University of Michigan. Rental: $22.00.

This film explores that intensely personal subject of universal concern, once considered taboo and still regarded as delicate in American society: death. In face-to-face interviews with courageous dying patients, ranging from a boy of 12 to older men and women, the film touches on such questions as "hopeless" medical situations, recent technical means for prolonging biological existence, solutions such as mercy killing and suicide, and the ability and best means for physicians and clergymen to deal with dying patients. The film indicates that society is at last making strides, if not in conquering death, at least in facing it.

APPENDIX A

Case Vignettes

Mr. Tyler Wants to Die

"I'd rather die now than be a cripple and a burden on my family the rest of my life." The nurse in charge of Royal Tyler had heard that kind of statement before, particularly from older patients. Sometimes those sentiments made sense to her, but not this time. True, Mr. Tyler was 72, and he had had a stroke. Right now, he had only limited use of his left arm and leg, and his heart would require medication and monitoring. Still, there was no reason for him to give up. His chances for recovery were good, or at least they would be if he would only cooperate with his prescribed medical regimen and physical therapy. On the other hand, if he continued to refuse to cooperate, he might just get his wish and die. "Well," the nurse thought, "it's out of my hands now. He's being discharged home. It's the medical social worker's problem now."

Melanie Dunhill, the social worker to whom Mr. Tyler's case was referred, had been with a private home care agency for the past fifteen years. Before that, she had worked with elderly patients as the coordinator of an out-reach program for a nursing home. Partially because of her experience, she was surprised by Mr. Tyler's attitude: he didn't seem like the kind of man who'd give up so easily. After he had retired from his job as a skilled factory worker, he had continued to supplement his social security and pension benefits by doing home repairs and yard work. He was something of a "man's man," vigorous, athletic, perhaps a little domineering towards his wife and family, but always attentive to them. And, until now, he had always been healthy. Now he was withdrawing, ready to quit.

Ms. Dunhill was not only confronted with the problem of getting Mr. Tyler to cooperate with his treatment, she was facing two time constraints. First, the longer Mr. Tyler delayed treatment, the less likely he was to regain the use of his arm and leg. Second, Mr. Tyler was on Medicare, and he had only limited coverage for home health services. Ms. Dunhill first had to get Mr. Tyler to agree to see her, and then, probably with only a few visits, she needed to convince him to cooperate with his own recovery.

Just getting to see Mr. Tyler was difficult. He refused to talk with Ms. Dunhill over the phone, telling his wife to tell her that he just wanted to be left alone. Ms. Dunhill could tell that Mrs. Tyler wanted her husband to get help, but she also realized that Ms. Tyler wasn't about to disagree with her husband. Finally, Ms. Dunhill went to the Tylers' home, hoping that Mrs. Tyler wouldn't refuse to let her in.

Mrs. Tyler did invite her inside, but she said that her husband was in bed and wouldn't see her. She showed Ms. Dunhill around the house, but she avoided talking about her husband's health. When they had returned to the front door, Mrs. Tyler finally began to cry, saying, "He was always the strong one. I just don't know what we're going to do now."

Hearing his mother cry, one of the Tylers' sons, Michael, about 40, came out of the den. He put his arms around his mother and turned almost violently toward Ms. Dunhill: "Why don't you get out of here and leave us alone. My father's got a right to die if he wants to. Nobody should try to stop him. Besides, he'll just end up like Bobby, anyway."

"Who's Bobby?" Ms. Dunhill asked.

"Our oldest boy," Mrs. Tyler answered. "He died two years ago of cancer. Took him almost a year to die."

Ms. Dunhill turned to Michael, "Let me see your father. It doesn't have to be like it was with Bobby."

Michael looked silently at Ms. Dunhill before responding, "Okay. I'll talk to him. But I don't think it'll do any good."

Ms. Dunhill and Mrs. Tyler waited downstairs for about 15 minutes. Finally, Michael returned and told Ms. Dunhill she could go up.

Mr. Tyler was lying in bed, looking away from the door, facing the wall. Ms. Dunhill noticed a double picture frame on one bedside table. One picture must have been Michael, 20 years ago, at a high school graduation. The other must have been Bobby. On the other bedside table was the picture of a woman with three small children--a daughter and grandchildren.

"Mr. Tyler, could we talk?"

Mr. Tyler turned his head. If Ms. Dunhill had expected a look of resignation and despair, she was wrong. He looked angry, defiant. He snapped, "Let's get this straight. All I want is for you to help me with these damn insurance forms. I don't want nobody bothering my wife when I'm gone. She's not in good health herself."

"Mr. Tyler, you don't have to be gone. Don't you understand? Listen, I know it must have been hard on you, with your oldest son, and now with this. But Bobby's case was different. He had cancer. You've had a stroke. That's serious, but you can get over it."

At the mention of his oldest son, Mr. Tyler had turned back to face the wall. His voice was only slightly less defiant. "Yeah. I know all that. But my son was only 42. I'm 72. What I got worth getting well for? What you got to say about that?"

That, as the nurse from the hospital might have said, was the social worker's problem, and she didn't have a whole lot of time to think of an answer.

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Adult Protective Services Worker Tries to Find the Answer

For Susan Ward, this case was turning into a nightmare. It was not what she had had in mind when she became a social worker. For fifteen years she had worked for her state's Adult Protective Service Agency. During those years, she had worked mostly with battered wives. She had found the work emotionally draining, but satisfying. She had helped to establish two safe houses for wives and children; she had helped literally hundreds of women; she had done a good job, and she felt good about her work.

But then she had been asked to help Sam Gray, and he was a different matter altogether. Her agency had been called by a state health officer who had attempted to investigate complaints that Mr. Gray's four large dogs were creating a sanitary nuisance and were a danger to the children of his neighborhood. When the health officer had arrived at Mr. Gray's house, he had found an unkept yard, a house with broken windows, and on the porch, an angry 84-year-old man who threatened to unleash his "pets" on the intruder. When the health officer tried to explain why he had come, the old man had become even angrier. He shouted, "You cops killed my wife, but I'm not going to let you take me. I'll shoot you and me both first." He then reached inside his front door and produced a rifle. The health officer decided not to try to explain that he wasn't a policeman. Instead, he left and called the Adult Protective Service Agency.

"I'm not sure why you're calling us," Ms. Ward had told the health officer. "Isn't this a case for the police? I mean, if you can't get this man to manage the dogs, and if he threatens you with a gun, don't you have to call the police?"

"Well, yes, I guess I should," the health officer responded. "But first of all, I don't really think he was going to shoot anyone. The main thing, though, is that the man looked sick. He was emaciated, and he couldn't stand straight. Even the dogs looked too thin; they're probably not eating right, either. And if I call the police, there's liable to be an argument--we do know he doesn't like the police--and they'd probably end up taking the dogs away. I just thought things might go better if you or somebody would talk to him first."

"What makes you think he'll talk to us, since he wouldn't talk to you?" Ms. Ward was already finding herself reluctant to go.

"Okay," the health officer said, rising to go. "Forget it. I'll call the police. I'd probably have to eventually, anyway. Something has to be done about those dogs."

"No. Wait. Let me talk to him first." Ms. Ward was resigning herself to the job.

She had the idea that she wasn't going to like Mr. Gray, but she tried to prepare herself mentally as she drove towards his house. After all, he was one more person in need of help. The neighborhood where Mr. Gray lived was a pleasant, working-class community. The houses were well kept. About half the children playing in the yards were Mexican-American, half were Anglo. Everyone was playing together. It seemed like a nice neighborhood, until you got to Mr. Gray's house. The brown grass was up to Ms. Ward's knees. The porch roof was caving in on one side; the support was re-inforced with two cinder blocks. The dogs were in the small, fenced-in back yard. They had worn away all the grass, and dust rose as they ran back and forth barking as Ms. Ward approached the house.

Mr. Gray was sitting on the porch, in a rocker, watching Ms. Ward come up the sidewalk. He broke his concentration only once, to spit tobacco juice over the side rail. "Lord," Ms. Ward thought to herself. "An honest-to-God California ranch hand. This one is not going to be fun."

But Mr. Gray was pleasant and polite when Ms. Ward explained who she was. She had decided it would be better not to mention the health officer; instead, she told Mr. Gray that some of his neighbors had called her agency because they were afraid he was not getting enough to eat.

"My neighbors?" Mr. Gray laughed, looked down at his feet, and shook his head. "That's real neighborly of them. Kinda surprises me, though. They'd be more help to me if they'd keep their damn kids away from my dogs. Broke all my windows, too--most likely the Beaner ones." Mr. Gray punctuated this last remark with another spit over the railing. "I suppose I've been a little under the weather, but I'll be all right soon enough--if people leave me alone."

Ms. Ward had been ready to leave him alone ever since the "Beaner" remark, but she asked Mr. Gray if he needed anything at all. To her surprise, he answered that he would appreciate a ride to the grocery store. When they got there, Mr. Gray bought two 20 lb. bags of Purina Dog Chow, 4 Swanson frozen T.V. dinners, and a six pack of Lucky Lager. He paid cash for the dog food and beer; he used food stamps for the T.V. dinners. It wasn't until he carried one bag of dog food to Ms. Ward's car and then went back for the other bag that Ms. Ward understood why he hadn't bought one cheaper 40 lb. bag. "I could have helped you with a bigger bag," she had said. He had pretended not to hear. On the way back to his house, Mr. Gray commented that he had a granddaughter "'bout your age" in San Isidro, but he wouldn't give her name or address. After he had carried the bags inside, he thanked Ms. Ward for the ride, went inside, and shut the door.

Ms. Ward walked around the neighborhood and talked to some of the neighbors. They reported that Mr. Gray never had visitors and that he rarely left the house, except to buy dog food. Some of the neighbors clearly suspected him of eating the dog food himself. They didn't like Mr. Gray, and they seemed honestly afraid of the dogs, particularly for their children. Mr. Gray was in the habit of shouting at the children, and some of the neighbors thought him capable of turning the dogs loose on a child. Ms. Ward was curious about the wife who, according to Mr. Gray, had been killed by the police, but none of the neighbors knew anything about a family; Mr. Gray had lived alone as long as any of them could remember.

Ms. Ward wasn't sure what, if anything, she should do. Mr. Gray didn't want her help. Perhaps he didn't need it. She knew that he was receiving both Social Security and food stamps. His health wasn't perfect, but he wasn't feeble. His personality wasn't what Ms. Ward would have preferred, but his mind was sharp enough, with the possible exception of the unexplained comment about his wife. The dogs, perhaps, were a problem, but as far as Ms. Ward was concerned, that was a problem for the neighbors, the health officer, and the police. So, she did nothing for a week.

Then the police called. They had Mr. Gray in custody. They had gone with the health officer to serve a complaint about the dogs. There had been words, and Mr. Gray's gun had gone off. The policy weren't charging him with trying to shoot anyone; the gun had been pointing straight up when it had gone off, and the police considered it an accident. They had, however, charged him with the illegal discharge of a weapon within city limits and with disturbing the peace. At Mr. Gray's insistence, they had provided him with legal counsel. A date for a hearing had been arranged, and Mr. Gray could leave. The police simply wanted someone to take him home. The health officer had given them Ms. Ward's phone number.

Ms. Ward talked to the lawyer at the station. He seemed to think that the charges were mostly the police's way of getting Mr. Gray in front of a judge, so that the judge could do something about the entire situation; the judge might agree to drop charges if Mr. Gray agreed to do something about the dogs. The lawyer also thought it possible that the judge might order a psychiatric examination.

"Could he do that?" Ms. Ward asked.

"Well, he certainly could--particularly if Mr. Gray starts raving about the police killing his wife. By the way, she died after a traffic accident 30 years ago. He's got it in his head that the state troopers are to blame for not saving her. Anyway, Ms. Ward, I think all the police want is for somebody--you, the judge, his family, anybody, but somebody--to make sure that this guy is taken care of. Isn't there something your agency could do?"

"Possibly. I don't know." Ms. Ward ws still unsure about what to do; somehow, she couldn't get a handle on this case. She decided to talk to her supervisor, Ms. Lewis. To her surprise, Ms. Lewis seemed very critical of her handling of the case.

"Susan, I don't want to be too hard on you. You've always been one of our best people. But do you honestly think you've done your best on this case? You're usually so good at getting people to open up to you. Is there some reason you can't work with Mr. Gray? Should I put someone else on this case?"

"Why, no. I mean, I don't think so. . . . Maybe." Ms. Ward was a little taken back, and she was confused about her own feelings. "What do you think, Ms. Lewis?"

* * *

Schmidt, Mary G. and Reyn Kinzey. In R.L. Schneider, T. Decker, J. Freeman, L. Messerschmidt, and C. Syran, eds. *Specialized Course Outlines for Gerontological Social Work Education*. Washington, DC: Council on Social Work Education, 1984, 44-46.

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Social Work and the Safety Net

Miss A., age eighty-five, appears in the emergency room of a large city hospital late one Saturday evening complaining of severe stomach pains. The examining physican does not find anything requiring immediate in-hospital medical treatment although the patient is dehydrated and malnourished. When the physician tells her she can leave, she begins to cry and refuses. A social worker is called. Miss A. tells the social worker that she still has severe pain in her abdomen. Besides, she was recently burglarized and mugged. Her apartment has no heat and there is nowhere else for her to go that evening. The social worker feels that Miss A. would be much better off in the hospital than in her apartment or in the streets but the physician does not want to use an acute-care bed for someone who does not need acute medical care and will inevitably be difficult to discharge.

* * *

Mrs. L., age thirty-five, comes to a mental health clinic complaining that she feels anxious, depressed, and jealous of her husband. She wants help in overcoming these feelings. In a separate meeting Mr. L. reveals to the social worker that he has been having continuing extramarital affairs over the years but does not want to tell his wife because he wants to maintain the marriage. The social worker is torn between a responsibility to help Mrs. L. and a duty to respect Mr. L.'s disclosure.

* * *

Mrs. H., a forty-four-year-old woman, develops cancer of the kidney which metastasizes to the lung, liver, and brain. Because of earlier psychiatric difficulties resulting in hospitalization for depression, the family asks the physician not to tell her that she has incurable cancer and he agrees. In her conversation with Mrs. H., the social worker senses that Mrs. H. is aware of her rapidly deteriorating condition and feels isolated and alone. The social worker questions whether it is proper to deny Mrs. H. the opportunity to make peace with her family and her God, to settle her own affairs, and to control her style of dying.

* * *

Mr. G., age ninety-six, has been hospitalized for a diagnostic work-up because of increasing incontinence. Although a severe hearing loss makes it difficult to communicate with him, he appears to be mentally alert and competent. After a few days of tests, the results of which are normal, Mr. G. refuses any further procedures and asks to be discharged. All he wants is to return home where he lives with his fifty-nine-year-old daughter and ninety-three-year-old wife who is dying of cancer. His daughter, a diabetic, does not feel that she can care for both her mother and father and wants Mr. G. placed in a nursing home. The physician asks the social worker to arrange a nursing home placement, but the social worker is uneasy about taking action that is contrary to Mr. G.'s expressed wishes.

* * *

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APPENDIX B

Hebrew Home of Greater Washington
Policy Guidelines for Treatment Orders at the End of Life

Care of the elderly includes care to the end of life. When a resident reaches the point where death is imminent, and attempts to prolong living would in fact be prolonging dying, the care team shall consider the wishes and values of the resident and next of kin before instituting, continuing or stopping invasive life-support measures. The definition of these measures is partly dependent on the situation, and cannot be predetermined, although the noninvasive provision of nutrition is usually obligatory and should be continued.

The decision to undertake life-support measures, or to stop them is a difficult one that must be addressed according to established principles and documented clearly to ensure appropriate care. The welfare of all parties--the patient, next of kin, staff and institution must be considered. Some principles to be used in such decision-making in these cases are:

1. The autonomous wishes of the dying person must be elicited (these wishes may be changed at any time).
   a. If these wishes are consistent with civil law and accepted standards of health care, the caretakers are obliged to abide by them.
   b. If the person cannot express autonomous wishes due to disability or lack of medical competence, staff must encourage discussions to determine the patient's values. Decisions should reflect the substituted judgement of the patient.
2. As a Jewish Home, the Hebrew Home adheres to Jewish law to the extent possible. When appropriate and when time permits, the interested parties will be informed by the staff of the availability of a panel of Halakic (Jewish Law) experts who can assist with ethical dilemmas.
3. The Hebrew Home has an Ethics committee of the Board which is available to assist patients, next of kin and staff to work through ethical dilemmas dealing with continuing treatment. The Ethics Committee should be called upon to discuss a case when, for example:
   a. There is a conflict between any of the involved parties--staff, resident, next of kin.
   b. The involved parties express the desire for discussion of the problem by the Ethics Committee.

    c. There is no next of kin or personal representative and the patient is not medically competent to make a decision.

4. Legal protection for the patient and the instiution is vitally important.

    a. The administration of the Home must be informed of every "No Treatment Order" or decision to maintain the life of a dying patient.

    b. Documentation must be clear, standardized, and explicit as detailed in the procedures manuals of the Home. Documentation must include the wishes of the resident, and/or next of kin/personal representative.

    c. Staff members shall not be forced to act contrary to their conscience or religious beliefs.

    d. There should be regular, appropriate reevaluation of status and patients/next of kin wishes as necessary. Changes of status and wishes must be recorded and documented.

5. Staff are urged to elicit the wishes and values of resident and/or next of kin/personal representative in the normal course of care and before the patient's condition becomes critical. These wishes shall be recorded and documented.

6. In the absense of any documented decision otherwise, the health care team is obligated to take all reasonable steps to maintain the life of the resident.

Revised, January 7, 1985

APPENDIX C

Guide for Autobiography

These questions are meant as a guide for your autobiography. You may feel that some of this information is personal in nature. Be assured that it will be treated as such. You will need to make a choice regarding what you are comfortable including and what you want to think about in private.

1. Describe your family of origin including information on: (a) composition/members (parents, siblings, birth order, etc.); (b) ethnic identity; (c) socio-cultural background; (d) neighborhood, etc.
2. Describe the intergenerational network in your family including information on: (a) frequency and type of contact; (b) your perception of the affective quality of relationships; and (c) what you feel you learned from your family about the process of dying or being "old."
3. Describe what you feel you have learned from your family about the process of dying or the meaning of death.
4. Describe your role in your family. What "part(s)" do you usually assume (see Goffman)? How did you come to assume the role of "helping person"?
5. Identify specific family expectations and values that you feel contributed to your career choice and/or interest in a "helping" profession. Who are the significant others that might have influenced career choice?
6. Identify the family's style of adaptation as seen in their problem solving techniques, reaction to stress and communication style. Have you felt comfortable in adopting and/or rejecting various "life solutions"?
7. Describe how your (family) life history impacts on your current functioning as a social worker. How might these past experiences impact on your philosophy of what constitutes "good" social work practice?

* * *

Greene, R. "Step on a Crack, Break an Old Man's Back: Learning Assignment for Social Work Students in the Field of Aging." Gerontology and Geriatrics Education, Vol. 3, No. 4, Summer 1983, pp. 307-312.

APPENDIX D

Facts on Aging: A Short Quiz

Erdman Palmore, Ph.D.[1]

Circle "T" for True, or "F" for False.[2]

T. F. 1. The majority of old people (past age 65) are senile (i.e., defective memory, disorientation, or demented).

T. F. 2. All five senses tend to decline in old age.

T. F. 3. Most old people have no interest in, or capacity for, sexual relations.

T. F. 4. Lung capacity tends to decline in old age.

T. F. 5. The majority of old people feel miserable most of the time.

T. F. 6. Physical strength tends to decline in old age.

T. F. 7. At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).

T. F. 8. Aged drivers have fewer accidents per person than drivers under 65.

T. F. 9. Most older workers cannot work as effectively as younger workers.

T. F. 10. About 80% of the aged are healthy enough to carry out their normal activities.

T. F. 11. Most old people are set in their ways and unable to change.

T. F. 12. Old people usually take longer to learn something new.

T. F. 13. It is almost impossible for most old people to learn new things.

T. F. 14. The reaction time of most old people tends to be slower than reaction time of younger people.

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[1] E. Palmore, "Facts on Aging: A Short Quiz," The Gerontologist 17 (1977): 315-320.

[2] Even numbered statements are true; odd numbered statements are false.

APPENDIX E

Nathan Kogan's "Old People" Items

	1	2	3	4	5	6
1. It would probably be better if most old people lived in residential units with people of their own age.	___	___	___	___	___	___
2. It would probably be better if most old people lived in residential units that also housed younger people.	___	___	___	___	___	___
3. There is something different about most old people; it's hard to figure out what makes them tick.	___	___	___	___	___	___
4. Most old people are really no different from anybody else; they're as easy to understand as younger people.	___	___	___	___	___	___
5. Most old people get set in their ways and are unable to change.	___	___	___	___	___	___
6. Most old people are capable of new adjustments when the situation demands it.	___	___	___	___	___	___
7. Most old people would prefer to quit work as soon as pensions or their children can support them.	___	___	___	___	___	___
8. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	___	___	___	___	___	___
9. Most old people tend to let their homes become shabby and unattractive.	___	___	___	___	___	___
10. Most old people can generally be counted on to maintain a clean, attractive home.	___	___	___	___	___	___
11. It is foolish to claim that wisdom comes with old age.	___	___	___	___	___	___
12. People grow wiser with the coming of old age.	___	___	___	___	___	___
13. Old people have too much power in business and politics.	___	___	___	___	___	___

		1	2	3	4	5	6
14.	Old people should have more power in business and politics.	___	___	___	___	___	___
15.	Most old people make one feel ill at ease.	___	___	___	___	___	___
16.	Most old people are very relaxing to be with.	___	___	___	___	___	___
17.	Most old people bore others by their insistence on talking about the "good old days."	___	___	___	___	___	___
18.	One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.	___	___	___	___	___	___
19.	Most old people spend too much time prying into the affairs of others and giving unsought advice.	___	___	___	___	___	___
20.	Most old people tend to keep to themselves and give advice only when asked.	___	___	___	___	___	___
21.	If old people expect to be liked, their first step is to try to get rid of their irritating faults.	___	___	___	___	___	___
22.	When you think about it, old people have the same faults as anybody else.	___	___	___	___	___	___
23.	In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.	___	___	___	___	___	___
24.	You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.	___	___	___	___	___	___
25.	There are a few exceptions, but in general most old people are pretty much alike.	___	___	___	___	___	___
26.	It is evident that most old people are very different from one another.	___	___	___	___	___	___

	1	2	3	4	5	6
27. Most old people should be more concerned with their personal appearance; they're too untidy.						
28. Most old people seem to be quite clean and neat in their personal appearance.						
29. Most old people ar irritable, grouchy, and unpleasant.						
30. Most old people are cheerful, agreeable, and good humored.						
31. Most old people are constantly complaining about the behavior of the younger generation.						
32. One seldom hears old people complaining about the behavior of the younger generation.						
33. Most old people make excessive demands for love and reassurance.						
34. Most old people need no more love and reassurance than anyone else.						

Matched pairs of statements: Odd numbers - negative
Even numbers - positive
Compare positive/negative mean scores

Kogan, N. "Attitudes Toward Old People: The Development of a Scale and an Examination of Correlates" Journal of Abnormal and Social Psychology, Vol. 62, No. 1, 1961, 44-54.

APPENDIX F

Newspaper Article

Cancer Patient Gets to Die 'Peacefully': Life Support Removed

A 71-year-old cancer patient died yesterday at Walter Reed Army Medical Center, about six hours after a federal judge ordered Army doctors to honor the woman's wishes by removing her from life-support equipment.

A hospital spokesman said the patient, Martha A. Tune of Falls Church, the widow of an Army lieutenant colonel, died "peacefully" at 3:55 p.m. with her son and daughter and other family members at her bedside.

A respirator tube providing oxygen to Tune was removed by doctors at 11:10 a.m., about one hour after U.S. District Judge Thomas Penfield Jackson signed an order granting her request that she be allowed "to die a dignified and natural death."

Tune, who suffered from cancer of the pericardium, the sac surrounding the heart, had been on the equipment since Sunday.

Jackson's decision came after an emergency hearing yesterday morning at which a court-appointed guardian for Tune told the judge the woman "understood she more than likely would die immediately" if life-support equipment was withdrawn.

The lawyer, James P. Schaller, said in court he had interviewed Tune at Walter Reed on Wednesday evening in an emotional session attended by family members.

"We were passing the Kleenex around and I was the biggest user," Schaller said.

According to Schaller, Tune wrote him a brief note during the interview. "I would like to get off the life-support system under which I am now having to live," the note said.

Army policy permits military doctors to withhold the use of life-prolonging equipment at a patient's request but prohibits removal of the equipment once it is in use, according to the hospital spokesman, Peter Esker.

The U.S. attorney's office, representing the Army, said in court that the government was taking no official position with regard to Tune's request.

Assistant U.S. Attorney Royce C. Lamberth, chief of the office's civil division, said that government lawyers were influenced by the fact that Tune was clearly mentally competent and expressed no doubts about her desire to die.

Tune's son and daughter and their spouses agreed that Tune's wishes should be honored, Lamberth said.

The government intervened to halt the removal of life-support equipment in a 1981 case in California involving a Veterans Administration Hospital.

But that patient was wavering about his desire to die, Lamberth said, and some family members were opposed to the move.

There was also a medical question about whether that patient was in terminal condition, according to Lamberth.

Tune's two-page request to the court that she be allowed to die was prepared by her son, Cecil C. Tune, a faculty member at Bob Jones University in South Carolina.

Martha Tune, whose husband died about 30 years ago, was admitted to Walter Reed on Feb. 21. Doctors first believed she was suffering from pneumonia. A test in which doctors extracted fluid from her pericardium showed she had cancer.

Tune had breast cancer 10 years ago but had had no recurrence of cancer until a week ago, according to Lamberth.

Schaller, the court-appointed guardian, said that Tune appeared "highly competent" during the 90-minute interview Wednesday night.

Schaller said Tune had written about 50 notes detailing which funeral director she wanted, which clothes she wished to be buried in, the fact that she preferred a closed casket, how she wanted her property disposed of and where to find it in her home.

* * *

Philip Smith, "Cancer Patient Gets to Die 'Peacefully': Life Support Removed," The Washington Post, Friday, March 1, 1985, C1, C4.

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ENHANCING SUPPORT NETWORKS

This module provides a theoretical framework for understanding social support systems that can assist practitioners in making appropriate interventions on behalf of the isolated and/or frail elderly. The use of network interventions is seen as an integral part of practice in the field of aging.

The content of this module focuses on:

- The nature of various support systems, their structural properties and dynamic features;
- Research questions about the effectiveness of social network intervention;
- The ways in which support networks can maintain the older adult in the community and contribute to well-being;
- The practitioner's role within the context of human service provision;
- Policy issues related to the relative contributions to be made by informal and formal support systems.

The objectives of this module are to provide training participants with:

- Increased knowledge about the properties of "natural support" systems; and
- Greater awareness of case situations in which the use of "natural support" systems can benefit the older client.

Defining Social Networks and Support Systems

This unit provides definitions of social networks and support systems from a number of points of view, offering participants an interrelational practice perspective.

The personal network can be understood as a "support system" involving the "giving and receiving of objects, services, social and emotional supports defined by the receiver and the giver as necessary or at least helpful in maintaining a style of life" (Lopata, 1975).

Social network analysis involves the qualitative and quantitative assessment of the individual's interpersonal relationships, the degree of integration into various organizational settings, and the availability of necessary supportive services (Snow & Gordon, 1980, p. 463).

A social support network is a set of interconnected relationships among a group of people that provide enduring patterns of nurturance (in any or all forms) and provides contingent reinforcement for efforts to cope with life on a day-to-day basis (Whittaker & Garbarino, 1983, p. 5).

Support systems are an "enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time" (Caplan, 1974, p. 7).

Social networks and social support are two different concepts. If networks are defined as the web of social relationships that surround a person and the characteristics of those linkages, social support can then be defined as the emotional, instrumental, or financial aid that is obtained from the social network (Berkman, 1983, p. 747).

Definitions

Definitions of the term "social network" tend to differ according to the perspective of the theorist. Mitchell (1969) stesses a network's utility in understanding human behavior, stating that a social network is a specific set of linkages among a defined set of persons. Barnes (1972), taking a structural point of view, maintains that a network is a set of points which are joined by lines. The points represent people or groups and how they interact with each other. Hooyman (1983), who stresses the distinction between formal and informal network, defines informal personal networks as a series of linkages along which information, emotional reassurances, and services flow to and from a person and his or her exchange relationships.

Many of the definitions of social network incorporate statements of perceived outcomes or benefits. For example, Walker (1977) proposes that social networks are the personal contacts through which social identity, emotional support, material aid, services, information, and new contacts are provided. Caplan states that support systems are attachments among individuals or between individuals and groups that serve to improve adaptive competence in dealing with short-term crises and life transitions as well as long-term challenges, stresses, and privations through (a) promoting emotional mastery, (b) offering guidance. . ., and (c) providing feedback about an individual's behavior. . . (Caplan, 1974, p. 31).

Because these definitions all convey the importance of the process of social support for the (older) client and the persons with whom he/she interacts, they suggest that practitioners should incorporate such a framework in their case planning and interventions with the aged. That framework offers a philosophy in which the complex interplay between individual and environment is taken into account, and all social systems are seen as potential resources to enhance or to create social support. Therefore, the interventions made on the client's behalf may consist of a whole range of activities which address the viability of personal networks. These varied forms of social support may be seen "as an integral part of practice rather than separating it out as a distinct strategy or method of intervention" (Whittaker & Garbarino, 1983, p. 47).

Sample Discussion Questions and Issues

Participants can be asked to provide examples of support networks from their own lives and from experiences with their clients.

What kind of questions would a practitioner ask in an interview with an older person to ascertain what informal support networks are available to him/her?

Research on Informal Support Systems

The research on informal support systems is not well developed in method or scope. This unit highlights the status of such research, and clarifies the need for having a more systematic understanding of the benefits of natural support systems intervention.

Research

A significant amount of gerontological research has been devoted to describing the informal social networks of older adults. These studies have provided ample documentation of the viability of family ties, and strong evidence that when older people need help they prefer to receive it from members of their informal support systems.

The literature suggests that informal social networks may affect help-seeking behavior, serve as a buffer from the effects of stressful life events, enhance well-being and life satisfaction, and influence rehabilitative success (Gourash, 1978; Thoits, 1982).

However, research has not yet substantiated the effectiveness of social network intervention. To date, there is "little empirical data on the efficacy of interventions with natural support systems." A majority of the available studies have employed imprecise definitions, and are "anecdotal, descriptive, retrospective, and noncontrolled." Other research difficulties result from the failure of most service programs to include an evaluation component, and that the effects of network interventions are difficult to measure (Cohen & Adler, 1984, p. 16; Froland _et_ _al_., 1981, p. 106).

Ward (1985) maintains that the lack of understanding about how best to support the roles and functions of informal networks represents an important gap in gerontological knowledge. He attributes this uncertainty to inadequate conceptualization and operationalization of the basic concepts related to social supports. Social support networks are multidimensional and composed of a variety of components. Therefore, research on the nature and consequences of support networks must attempt to address these multiple factors. In addition, research designs must be constructed to tap both the objective/quantitative and subjective/qualitative dimensions of support networks. The following study, which evaluates the effectiveness of a network intervention program, is one attempt at such research.

Cohen, C.I., and Adler, A. "Network Interventions: Do They Work?" _The Gerontologist_, 24, _1_ (1984), 16-22.

This article provides information on the results of a research project which systematically evaluates an experimental program on the use of network interventions. The network service program was conducted in a large single room occupancy (SRO) hotel in midtown Manhattan. (The sample was comprised of 156 hotel residents who received assistance during a 15-month period.) Answers to three research questions were sought: (1) Which types of presenting problems can be dealt with successfully solely through a network intervention? (2) Which characteristics of clients are conducive to network successes or failures? and (3) What are the factors that serve to inhibit network interventions? Problems addressed involved issues of emotional support, physical health, income, hotel conditions, and information and advice. Results of the study indicate that only 16 percent of problems were successfully dealt with through a network intervention. (No network interventions were employed for approximately one-half of the problems presented.) The authors concluded that network interventions are more successful when they are most like or have been a part of the population's "cultural context." They also suggested that the optimism surrounding the use of networks as a service technique must be reassessed.

Sample Discussion Questions and Issues

Why do you think it is difficult to help certain inner city populations (as described in this article) through network interventions? E.g., are such interventions culturally relevant?

How would you go about designing an outreach program for an SRO population group? What factors need to be considered?

Biopsychosocial Process of Aging

Practitioners who wish to establish support networks on behalf of the isolated and/or frail elderly need an understanding of the basic biopsychosocial processes of aging as well as the specialized knowledge related to the dynamics of social support systems. This unit outlines several theoretical perspectives that can be employed to evaluate the older person's relative position in his/her social network.

Human Behavior

"Networks are interconnected relationships, durable patterns of interaction, and interpersonal threads that comprise a social fabric" (Whittaker & Garbarino, 1983, p. 4). As such, these established networks offer the opportunity to examine "the nature and process of relatedness of the person and [his/her] social system" (Snow & Gordon, 1980). By assessing the person with reference to his/her social system, the practitioner can develop a better understanding of the client's relationship to his/her environment and the nature of his/her community supports. In the broadest terms, these supports may include the neighborhood pharmacist or butcher, a pet, a community park, senior center, or museum.

There are a number of theoretical perspectives which lend differing views of social networks in old age. Disengagement theory, activity theory, developmental theory, and/or systems theory are among the relevant constructs.

Activity and disengagement theory both address the degree to which an older person's involvement in a social network affects his/her sense of well-being. Activity theory suggests that the older person must continue to perform what might be considered "middle-aged roles" in order to preserve morale and sustain self-concepts. Disengagement theory, on the other hand, proposes that there is a process of [mutual] withdrawal from social participation as the individual ages. This view is controversial as it reflects the assumption that a decline in social contacts is universal, inevitable, and functional for both the older adult and society. It also has been suggested that the cultural dimensions of disengagement have not been sufficiently researched, and may vary with such factors as social class, ethnic group membership, and rural or urban setting (Cantor, 1975; Krishof & Yollin, 1981; Spohn, 1982; Thurmond, 1980). Developmental theory, which assumes that personality and social orientations evolve throughout the life cycle, suggests that there is a continuation of life-long social patterns as people age. However, developmental psychologists often see the older adult as gradually turning inward or becoming more introspective over the life course, thus becoming less attuned to social relationships (Hooyman, 1983, pp. 136-137).

Social network analysis can perhaps best be thought of in the context of social systems theory. While the focus of community treatment is often the individual in need of help, systems theory emphasizes the social network(s) surrounding the person. In this way, "symptoms, defenses, character structure and personality are regarded as terms describing the individual's typical interaction which occurs in response to a particular context, rather than as intrapsychic entities" (Jackson, 1967, p. 140). By examining the system's properties of support networks, the practitioner can come to understand the client's behavior in terms of his/her location within a social network (Cohen & Sokolovsky, 1979).

Ward (1985) suggests that a distinction can be made between the structural and functional features of support systems: Measures of network structure or the objective/quantitative properties might include an evaluation of network size (number), proximity, frequency of contact, stability or change, density (the ties of network members with one another), and symmetry (reciprocity versus one-directional exchange); while investigations of network function or the subjective/qualitative features might involve the assessment of the nature of social contacts, e.g., degree of openness, intimacy, conflict, obligation, or strain (p. 57).

At issue here are the practice implications of each of these theories.

> Practitioners need to recognize the influences these different theories have on their expectations of the elderly's appropriate role and behavior. Whether one believes that aging is a withdrawal from active participation, that activity is essential to successful aging, that how one ages depends on lifelong habits of coping..., the theory in each case clearly affects the way in which providers perceive and interact with an older person and the kinds of interventions they are likely to use (Hooyman, 1983, pp. 136-137).

Sample Discussion Questions and Issues

What are the differences and similarities among the theoretical perspectives of aging--disengagement, activity, developmental and systems theory?

What implications for assessment, treatment, planning, policy, etc., can be made from each of these different theories?

Brief case situations found in Appendix A to this module are provided for discussion.

Social Network Interventions

Social network analysis and network interventions require that the practitioner be able to perform a number of professional roles ranging from advocate to consultant based upon a biopsychosocial assessment.

As Snow and Gordon (1980) maintain, the purpose of a social network analysis is to provide a basis for understanding the nature of the client's social participation, and the availability, accessibility, and usefulness of necessary support services. In order to accomplish this, information should be gathered on the structural and dynamic features of the social network, and on the individual's subjective view or meaning of his/her support system(s). The individual's approach to problem-solving, significant life events, and the cultural, economic, and political context in which they take place all need to be taken into consideration.

Forms of social treatment have long been a part of human services provision. However, during the 1940s and 1950s as the office interview tended to replace neighborhood visiting, practitioners became less aware of community networks and thereby placed less emphasis on environmental intervention. Over the last two decades, there has been a "re-discovery" of social support networks, and many types of treatment strategies now fall under the rubric of social network intervention.

Froland et al. (1981, pp. 64-65) have identified five interventive strategies to link formal and informal networks:

- the personal network strategy in which professional staff consult, support, and assist the informal helping efforts of family, friends, and neighbors (e.g., respite care);
- the volunteer linking strategy whereby lay helpers and clients with limited social supports are matched (e.g., friendly visitors);
- the mutual aid strategy, when individuals with common problems, interests and/or concerns are brought together to share resources and reduce isolation (e.g., "operation match");
- the neighborhood helping strategy, in which the efforts of community members already in supportive roles are enhanced (e.g., helping a person connect with church-sponsored meals-on-wheels); and
- community empowerment, in which ties among informal opinion leaders within the community are strengthened to work for improved services and satisfy unmet needs (e.g., giving talks to community groups).

In their book Building Support Networks for the Elderly, Biegel, Shore and Gordon (1984) identify seven types of social network interventions. While four of the seven interventions identified--neighborhood helping, volunteer linking, mutual help and community empowerment--overlap with those of Froland *et al.*, the discussion is tailored to programs for the elderly. Other interventions addressed include: (1) clinical treatment, which stresses the importance of an individual's support system to his/her mental health; (2) family caregiver enhancement, which involves interventions to lessen family burden; and (3) case management, which aims to coordinate a variety of public and private services for the maximum benefit of the client.

Sample Discussion Questions and Issues

Each type of network intervention requires a somewhat different application of knowledge base and expertise. In order for training participants to more clearly identify the skills needed for a particular professional role or function, it is suggested that time be allotted for a series of cases which illustrate a variety of helping strategies. Consideration should also be given to expanding the number of functions the practitioner is able to carry out. Trainers should obtain feedback from participants about their needs in their respective settings.

Two case examples are provided in Appendix A, but participants should be encouraged to bring to the training their own cases for discussion.

Policy Issues

The purpose of this unit is to identify and explore some of the policy issues related to the relative contributions of formal versus informal support systems in supporting the well-being of the elderly client.

In all societies, to varying degrees, the responsibility for providing care and services for the frail and/or impaired elderly is assumed by the informal social support systems (family, friends, and neighbors), and the formal service structures (public and private agencies and programs that provide income maintenance, health and social services) (Shanas, 1979). This shared responsibility raises a number of policy questions. The caretaking relationship is more than a product of the emotional bond between parents and children; it is also shaped by demographic trends, economic and political considerations, and cultural values and beliefs. As a result, the issues are complex. Questions which have been raised include how working women provide care for infirm relatives, and what financial incentives can be legislated to make it feasible for relatives to provide supports and care for elderly family members.

An important policy issue is raised in the Report of the President's Commission on Mental Health (1978). It cautions that the desire to strengthen the natural networks carries with it the possibility of using such supports to "justify public policies which would withhold from various communities and individuals the resources they need to obtain professional and formal institutional services." Because of this danger, Snow and Gordon (1980) propose that it is necessary to evaluate the risks and gains of reliance on either formal or informal social networks. They go on to suggest that the first step in this process is to clarify the concept (of social support) itself.

At the 1981 White House Conference on Aging a number of questions on family, social services and other support systems were raised (see Report of Technical Committee, 1981, as discussed in Module 3). Once again, a major concern was the relative contributions to be made by the formal and the informal support systems in assuring that "a comprehensive continuum of services be available to the older person" . . . "in order to contribute to the well-being and quality of life."

The question of how to best use alternative sources of help, particularly those that can be provided by the informal support systems, involves issues not only of policy but of philosophy. Rosenmayr's (1975) statement stimulates thought in that regard:

> Public action to give support to the elderly has the innate danger to classify them as marginal. It is the dialectics of institutionally organized help to a certain group that this group becomes conscious of a certain bereavement; whereas individual and informal help and assistance based on intimacy may avoid this type of consequences. . . .

Sample Discussion Questions and Issues

What are the values of formal versus informal support networks?

What are the potential effects of a public policy that acknowledges and emphasizes only the value of informal supports for the elderly?

Does the creation of formal supports contribute to decreased utilization of informal support networks?

Self-Help Groups

The purpose of this unit is to identify self-help groups as a particular form of "informal" supports, and explore the role of the professional in self-help groups.

Definitions

> Self-help groups "are characterized by small numbers of persons, mostly nonprofessionals, who meet on a regular basis for the purpose of sharing accounts of similar personal experiences, discussing coping strategies, engendering mutual support, and identifying and gaining access to community resources" (Haber, 1983, p. 251).
>
> Self-help organizations often serve a population not in contact with formal caregiving agencies. "They are half-way between a folk care system and a professional care system" (Killilea, 1976, p. 47).
>
> Self-help intervention strategies involve "the development of ties between elderly individuals. A major aspect of this intervention is the mutuality involved in the helping process. Persons serve both as providers of help to those others with whom they are linked and as receivers of help from those same individuals" (Biegel *et al*., 1984, p. 123).

Self-Help Groups

Self-help and mutual help groups exist in our society along with a growing number of peer-oriented helping networks and associations, such as support groups for family caregivers and consciousness raising and political action associations (Killilea, 1976, p. 39). It has been estimated that there are well over one-half million self-help groups in the United States concerned with a broad range of psychological, social, medical, and environmental problems. The size and structure of these groups range from small local affiliations to large organizations of national scope. Together, they serve over fifteen million people (Toseland & Hacker, 1982, p. 341).

Mutual help groups are distinguished by mutuality in the helping process rather than reliance solely on professional problem-solving techniques (see Appendix B) (Biegel, Shore, & Gordon, 1984). These groups provide mutual support and guidance in relation to a particular problem, and may also serve as alternative caregiving systems or an element of a planned system of care, act as a social movement, or a supplementary community, and offer a therapeutic milieu (see Killilea, 1976).

Haber (1983) suggests that there are four major advantages to mutual self-help groups: (1) providing support over a long period of time without cost, (2) sharing personal experiences that bring about understanding and depth of feeling sometimes not reached with a professional worker, (3) decentralizing services in a time of dwindling human services and resources, and (4) strengthening networks in the community.

Professional Roles with Self-Help Groups

Contrary to popular opinion, with few exceptions, self-help groups are not antiprofessional. In actual practice, human service professionals can play a variety of roles in working with self-help groups. These roles include: (1) providing material support, (2) serving as a linkage to traditional services, (3) serving as a consultant, and (4) initiating and developing a self-help group (Biegel et al., 1984; Toseland & Hacker, 1982).

It is the community-building aspect of self-help groups that is perhaps of major interest to the practitioner in gerontology. While many self-help groups have volunteer or lay-leadership, they are often started with the assistance of churches, community organizations, and community health centers (Biegel et al., 1984; Ross, 1978). This is especially prevalent in communities that have a long history of mutual aid societies, as seen, for example, in the role of the black church (Frazier & Lincoln, 1974). In this context, such groups serve as a means for rendering group cohesion (Beaver & Miller, 1985). Mellor et al. (1979) suggest that

> a self-help group approach is particularly well-suited for use with groups of caregivers of the aged because: They are a recently-identified population and the professional service network is only just beginning to recognize the needs of these caregivers. Caregivers possess the necessary expertise and hold many of the solutions to their own problems. Group meetings can be a conduit for this knowledge between caregivers. This self-help approach also translates into greater investment on the part of the group members by virtue of their sense of ownership (p. 273).

Practitioners working with the aged are also interested in the potential therapeutic value provided by self-help groups (Silverman, 1976, 1980). However, the role of the human service professional in relation to such self-help programs is often ambiguous. The group members may not accept the professional as "one of their own," or may feel that they want to develop their own network of support, while practitioners often see the growth of self-help as undermining the profession (Mellor et al., 1979). Wasow (1985) suggests that these issues can sometimes be resolved by discussing them directly with the group and/or through the use of a co-therapist who is an accepted member of the group.

On the other hand, human service workers are more likely than other professionals to be involved in the initiation and development of self-help groups. Where they have become successfully involved, there has been an emphasis on the professional gaining a sufficient understanding of the group members' problems and concerns, following the original format of the group, demonstrating egalitarianism, and making appropriate referrals to the group (Toseland & Hacker, 1982).

Clearly, the clarification of one's professional role is at the heart of the process of working with self-help groups. There are any number of professionals' roles that might be appropriate to use in this context--advocate, consultant, facilitator, initiator-developer, and resource provider (see Biegel et al., 1984). However, advance planning, which takes into account the characteristics and needs of group members as well as the professional stance of the practitioner, is essential. For example, the American Association for the Blind has developed a program of self-help peer discussion groups for older persons with sensory loss (American Federation for the Blind). The program stresses the philosophy that anyone interested in sensory problems can participate and benefit and that "no prior experience is necessary to lead an effective self-help discussion" (see Biegel et al., 1984).

Sample Discussion Questions and Issues

Training participants can be asked to describe self-help groups they have encountered or worked with directly in their practice with the elderly.

What were the negatives and positives of those experiences?

In order for workshop participants to come to appreciate some of the issues related to the use of professionals in self-help groups, it is suggested that time be allowed to explore attitudes toward this form of intervention.

Summary of Practice Implications and Training Suggestions

Most elderly individuals are involved in a number of support networks, the most important of which is the family. In fact, even the most frail and apparently isolated and vulnerable elderly generally have some informal support networks. The presence or absence of such networks is a crucial predictor of an older person's sense of well-being and autonomy (Hooyman, 1983).

There are, however, those older persons who have few or tenuous social supports. This may come about through illness, the loss of mobility, a change of residence or the death of one's peer group. In addition, there are those older people who have always been isolates, with few if any friends, estranged from family, and/or reluctant to use formal community resources. Each of these "types of clients" requires a different plan of intervention and strategy to mobilize informal support systems.

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Biegel, D.E., Shore, B.K., and Gordon, E. Building Support Networks for the Elderly. Beverly Hills, CA: Sage Publications, 1984.

This is a thorough, well-written, practice-oriented book on social network intervention with the elderly. The authors first collected information on existing programs and models that address the social support needs of the aged. A typology was developed to organize and systematize this material and make it useful for agency practitioners. As a result, seven types of network intervention programs are described: clinical treatment, family caregiver enhancement, case management, neighborhood helping, volunteer linking, mutual and self-help and community empowerment.

Caplan, G., and Killilea, M. Support Systems and Mutual Help: Multi disciplinary Explorations of Social Work with Groups. New York: Grune & Stratton, 1976.

This book contains a series of articles pertaining to natural support systems including the family and a variety of mutual help organizations. Among those of interest to the geriatric social worker are "The Widow as a Caregiver in a Program of Preventive Intervention with other Widows" and "Peer Consultation Among Clergy: A Resource for Professional Development."

Clark, N. and Rakowski, W. "Family Caregivers of Older Adults: Improving Helping Skills," The Gerontologist, 23, 6 (1983), 637-642.

This paper addresses the educational aspects of programs designed to assist family caregivers. Major tasks in providing assistance are summarized from research and program reports. Existing literature describing education and support programs is discussed and areas of needed research and program development are identified. This article will be useful to those who want to cover material in which practice, research and policy issues may all be addressed.

Cohen, C.I., and Sokolovsky, J. "Clinical Use of Network Analysis for Psychiatric and Aged Populations." Community Mental Health Journal, 15 (1979), 203-213.

This article calls for a systematic therapeutic approach to be used in working with natural community support networks and self-help groups. It suggests that network analysis can provide quantitative and qualitative data useful in therapeutic interventions and agency planning decisions. The authors present an instrument for analysis of networks that has both research and therapeutic applicability. The "Network Analysis Profile" is intended to chart the parameters of interaction of inner-city hotel dwellers, and is seen as appropriate for use in viewing "behavior in terms of a client's location within a network system," for identifying indigenous leaders, and as part of standard intake data.

Goodman, C.C. "Natural Helping Among Older Adults," *The Gerontologist*, 24, *2* (1984), 138-143.

This article reports the results of a study in which a sample of 67 elderly persons who were neighbors in retirement housing were organized into a support network. They were surveyed (2-hour interviews using open-ended questions) to identify distinguishing characteristics and natural helping styles within their informal support systems. Findings suggested a typology of three neighborhood exchange types: (1) high-helpers, who exhibit a "quasiprofessional style of helping without reciprocation"; (2) mutual-helpers, who show an interdependent style of give and take; and (3) neighborhood-isolates, whose social ties and help sources are primarily outside the neighborhood. The authors conclude that the helping styles described offer ideas for service delivery through the use of volunteer programs and self-help groups.

Gross-Andrew, S., and Zimmer, A. "Incentives to Families Caring for Disabled Elderly," *Journal of Gerontological Social Work*, 1, *2* (Winter 1978), 119-133.

This paper is a preliminary report from the New York Community Service Society Natural Supports Research and Demonstration Project. The goal of the project was to provide services to families in order to strengthen their capacity to care for their aged member(s). Among the interests of the project was the actual work performed by families in the course of providing care to an elderly disabled member, as well as the disruption experienced by families in providing this care. Home Care services were provide to supplement the family's. The impact of these interventions was examined using a semistructured interview with the family at the initiation of service and at six-month intervals. Preliminary results indicated that clients reported alleviation of stress or disruption in their lives in emotional, physical, social, and financial terms.

Hooyman, N. "Social Support Networks in Services to the Elderly." In J.K. Whitaker and J. Garbarino, eds. *Social Support Networks* (New York: Aldine Publishing Co., 1983).

This chapter reviews the existing knowledge about social supports for older people, identifies situations encountered in professional practice that are amenable to network interventions, describes programs designed to create or strengthen informal supports, and points to directions for research and practice. Demographic and social-psychological characteristics of the elderly are first reviewed, thereby highlighting the need for network interventions as one way to address the multiple health and social problems facing older people. Issues related to social support networks which the author describes are: remaining in one's own home, moving in with family, and entering a nursing home.

Killilea, M. "Mutual Help Organizations: Interpretations in the Literature." In G. Caplan and M. Killilea, eds. Support Systems and Mutual Help Multidisciplinary Explorations of Social Work with Groups. New York: Grune and Stratton, 1976.

This book chapter systematically reviews the literature on self-help and mutual help groups. Although the literature would not be up to date, the scheme used to organize the material is most helpful. The author suggests that mutual help groups can act as a social movement, a spiritual movement, a product of social and political forces, a subculture, a phenomenon of the service society, an expression of democratic ideals, an alternative caregiving system, an adjunct to professions, an element of a planned system of care, a therapeutic method, a vehicle to aid with life transitions, agencies of social control and resocialization, organizations of the deviant and stigmatized, expressive social influence groups, and supplementary intentional or temporary communities. The literature dealing with each approach is presented.

Pynoos, J., Hade-Kaplan, B., and Fleisher, D. "Intergenerational Neighborhood Networks: A Basis Seen Aiding the Frail Elderly." The Gerontologist, 24, 3 (1984), 233-237.

The authors describe Project LINC (Living Independently through Neighborhood Cooperation) in which a neighborhood is organized to help each other and meet the special needs of the frail elderly. The purpose of the recently-completed three-year research and demonstration project was to organize residents of all ages into neighborhood-based helping networks and link those networks to community agencies for access to additional resources as they were needed. Neighborhood networks, indigenous leaders, social clubs, an exchange bank and a service exchange (involving the students of a local high school) were all components of the project. The evaluation indicated that the frail elderly did receive more services, and that more volunteers, new friendships, social activities and life satisfaction resulted.

Ross, H. How to Develop a Neighborhood Family. Miami, FL: University of Miami, 1978.

This manual provides step-by-step information on how to create a neighborhood network. The project combines social action with the provision of medical and social services through the efforts of a community mental health center, city hospital and the neighborhood support network (see Ross, 1983).

Ross, H.K. "The Neighborhood Family: Community Mental Health for the Elderly." The Gerontologist, 23, 3 (1983), 243-247.

This article outlines a mental health project of the University of Miami-Jackson Memorial Community Mental Health Center to etablish an alternative model of geriatric services. The new model, which began with community organization of the elderly residents of a selected target area, was called the Neighborhood Family (NF). The Neighborhood Family is based on the premise that older persons can create a self-managed social support network from which they assess needs and develop a spectrum of responsive services. The model combines a kin-like supportive community, a multipurpose service and activities center, minimal staff, and indigenous decision-making. The development of two NFs serving white and black elderly is described.

Snow, D., and Gordon, J. "Social Network Analyses and Intervention with the Elderly." The Gerontologist, 20, 4 (1980), 463-467.

The purpose of this paper is to present an approach to the study of social networks and to demonstrate the applicability of network analysis in determining intervention strategies with the elderly. The authors suggest that this type of analysis reveals strengths within the network to be reinforced or negative influences that need to be removed or modified. The authors also evaluate the risks and gain of network analysis and intervention, and consider certain policy implications.

Special Committee on Aging. United States Senate, Hearing: Older Americans in the Nation's Neighborhoods. Washington, DC: U.S. Government Printing Office, 1979, pp. 45-495.

These Hearings provide an excellent case-study focus for practitioners interested in the policy/political ramifications of neighborhood support systems. Testimony is presented from a range of witnesses representing diverse organizations such as the Neighborhood Senior Services, Inc. and the Conservation Foundation. The committee's interest is both neighborhood conservation and renewal as well as policymaking regarding the many poor elderly living in inner cities. Witnesses reflect the diversity of opinions on this topic.

Ward, R. "Informal Networks and Well-Being in Later Life: A Research Agenda." The Gerontologist, 25, 1 (1985), 55-61.

The author of this article raises important questions about the "inadequate conceptualization and operationalization of 'social support.'" He maintains that most research on the networks of older people has investigated quantity of relationships rather than quality. He asks whether research has, therefore, substantiated the "direct contributions of social support to the well-being" of the aged person, and offers a model to explore this question.

The 1981 White House Conference on Aging. Report of Technical Committee on Family Social Services and Other Support Systems. Washington, DC: Department of Health and Human Services, 1981.

The Technical Committee suggests a policy agenda in regard to the use of private and public resources in order to provide a continuum of services to older people, without regard to income, minority status, geographic location or any other variables. The report describes the historical and current status of the family, social services, and other support systems, raises key issues and makes recommendations to educate and support caregivers.

Zimmer, A. "Community Care for the Aged: The Natural Supports Program." Gerontological Social Work Practice in Long-Term Care, pp. 149-155.

This article presents the results of the innovative work of the Community Service Society's Natural Supports Program. During the period 1976 to 1981 two different service modalities were implemented: (1) task-centered social casework with caregiving families, (2) the development of community-based support groups for family, friends and neighbors of the disabled. Services to families included home care, respite for the caregivers, counseling, escort service and assistance and advocacy regarding entitlement. Groups provided concrete service needs (education and skills training), peer support, and advocacy.

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APPENDIX A

Example Case Situations

Mrs. A's family buys her an apartment in a Senior building at great expense because they want her to enjoy social interaction. She sits in her room and is identified as queer by others. Family in another city think she is now provided for. Mrs. A. was always an isolate--enjoyed her privacy and would have been happy living with family in suburb and knitting and reading.

Mrs. B. was widely traveled--enjoyed theater--always volunteered--very actively involved. Now at 83 she may be suffering from Alzheimer's. She is somewhat confused and not able to concentrate or socialize. Instead of putting her in a good home with activities structure and protection, family keep her at home. They (family) both work and the aide has nothing in common with Mrs. B.

APPENDIX B

Self-Help Continuum for Groups

Professionally led group Dependence on leader Lack of sharing No commitment to group Passive	Professional leader Peer support Mutual aid but only within group setting Leader recruits members Members defer to leader in decision making	Professional leader is resource person and facilitator No formal leadership Mutual aid within and without group setting Peer support Some social action Recruits own members and accepts referrals	No professional present but reliance on professional contact Social action/ personal change Peer support, mutual aid Recruits members and accepts referrals Ego reinforcement	Nonprofessional leader or no leader Members plan and expedite activities Social action/ personal change Mutual aid, peer support Recruits own members Ego reinforcement
-- NO SELF-HELP				+ SELF-HELP

Natural Supports Program
All groups fall somewhere along this continuum. Groups may move in either direction or back and forth over a period of time.

Mellor, Retzelny, and Hudis, "Self-Help Groups for Caregivers of the Aged." In S.L. Abels and P. Abels, eds. Social Work with Groups. Proceedings of 1979 Symposium Committee for the Advancement of Social Work Groups, Louisville, Kentucky.

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THE LONG-TERM CARE CONTINUUM: COMMUNITY LIVING AND INSTITUTIONALIZATION

In this module the long-term care service network and the role of the practitioner in service delivery is examined. Although human service professionals practice in a variety of settings and fulfill different functions within the field of aging, there are a number of generic practice issues and skill requirements.

The objectives of this module are to:

- Describe the long-term care system as a continuum of care;
- Define the role and relevance of case management as it relates to service delivery;
- Outline the benefits of professional interventions in long-term care;
- Highlight policy issues related to financing of care through current experimental funding programs.

The anticipated outcomes of this training module are to:

- Identify the components of the long-term care system;
- Define the role of case managers;
- Increase knowledge of the practitioner's role in planning, lobbying and establishing community services for the frail and/or impaired elderly adults;
- Heighten awareness of current policy issues and their impact on service delivery;
- Increase knowledge of research in the long-term care arena and identify its application to practice.

The Long-Term Care System

The purpose of this unit is to describe the ideal long-term care system as a method of service delivery which offers medical and psychosocial services along a continuum of care.

Definition

Long-term care refers to a range of services that address the health, psychosocial and personal care needs of individuals who lack some capacity for self-care. It encompasses resident facilities as well as social service and health programs, and is designed to provide supportive care for an individual over a prolonged period of time at home or in a variety of protective and semi-protective settings.

The focus of the long-term care system is the person who is frail or has a functional disability (and his/her support system) (see Module #2) and needs assistance with activities of daily living such as housekeeping, finances, transportation, meal preparation or the administration of medication.

A well-developed long-term care system should provide services and facilities to meet the needs for services along a continuum of care. In order to create a well-developed long-term care system, sufficient attention must be paid to establishing linkages and filling gaps so that resources include home- and community-based options as well as residential facilities.

The professional staff within the long-term care system assess the individual, matching the level of impairment with the type of services rendered. The case management process is within the framework of generic human service practice. It is a mechanism for ensuring a comprehensive program for meeting an individual's need for care by coordinating and linking components of a service delivery system (NASW Standards and Guidelines, 1984).

The Continuum of Care

Long-term care traditionally has been associated with the instituional care of adults. Today, however, the term encompasses a whole range of community services (Iowa Gerontology Model Project, 1982). The continuum of community-based long-term care services generally includes:

1. Outreach and case findings or screenings services - locating the ill, but untreated, and the still-functioning elderly who may be at risk.

2. Comprehensive assessment services - evaluating the older individual in order to determine the need for service.

3. Primary care; medical, dental and nursing services - providing the core health maintenance in response to acute illness.

4. Home support services - supplying necessary in-home management and personal care of older persons.

5. Home health care services - assisting the chronically ill with nursing and related personal health care including social services.

6. Day health care or daycare services - providing daytime care to frail or impaired individuals to improve or maintain levels of social, emotional and health functions and respite to families.

7. Day hospital (rehabilitation) services - rehabilitating the older person stricken with physical illness and impairments which are amenable to rehabilitation and retraining.

8. Home hospice service - serving the terminally ill with pain management, counseling and home supports.

Sample Discussion Questions and Issues

Appendix A to this module continues a visual representation of the continuum of care that can be duplicated and distributed to training participants.

Have any of the training participants directly provided or referred clients for any of the services listed on the continuum of care? If so, did they think of the services as part of long-term care?

What makes care "long-term"? Attributes of the care and/or services provided? Types of clients served? Problems presented?

A case vignette is provided in Appendix B. This case can be duplicated and provided to participants for the purpose of group discussion.

Research on Long-Term Care

The purpose of this unit is to familiarize participants with selected research on long-term care. The studies cited represent those most relevant to the case manager in a direct service function. If preregistration information indicates that many participants are in other spheres of case management, the trainer may want to modify the selection.

Public agencies are finding it necessary to evaluate their ongoing and new programs in order to justify their existence. "Cost-effectiveness, accountability, and zero-based budgeting are all newer and important concepts in social agency vocabularies. All require systematizing information systems, process monitoring, and program evaluation" (Miller, p. 113). Trainees need to be able to translate this approach to program development to the field of aging where there will be a growing demand to demonstrate that "new" services are "better" than their predecessors through research.
In essence, practitioners involved in the planning, delivery, and management of long-term care services need to keep as up-to-date as possible on current research issues. The practitioners involved in the planning and delivery of long-term care would be particularly interested in those research questions which are derived from experience and for which the findings have immediate application. While there may be implications for theory building, the purpose of the applied research is not to test a theory, but to explore or assess ideas, experiences, and approaches which derive from practice itself. In short, applied research is concerned with translating existing knowledge into applications. It differs from basic research in that it seeks to reduce theoretical ideas to a "useful" purpose. In this case it furthers the specific mission of the agency in meeting the needs of clients and is frequently a forerunner of development.

Briar (1979) has used the term "clinical scientist" for the direct practitioner who 1) uses with his or her clients the practice methods and techniques that are known empirically to be most effective; 2) continuously and rigorously evaluates his/her own practice; 3) participates in the discovery, testing, and reporting of more effective ways of helping clients; 4) uses untested, unvalidated practice methods and techniques cautiously and only with adequate control, evaluation, and attention to client rights; 5) communicates the results of his/her evaluations of practice to others" (p. 132-133).

Applied research on long-term care may provide data to improve and modify resources. Research may focus on the quality of care, eligibility standards, or alternative service delivery. The diversity of studies on long-term care reflects the growing interest and concern about the wide variety of programs, services and facilities available. Studies range from those that examine the relative merits of treatment modalities for institutionalized aged to those that evaluate the relative costs of nursing home versus community-based home health care.

Example articles dealing with the differential usage of services by the impaired elderly, factors leading to institutionalization, and the interplay between informal and formal support networks are provided below.

Smyer, M. "The Differential Usage of Services by Impaired Elderly." *Journal of Gerontology*, 35, *2* (1980), 249-255.

This study provides information on differential service usage among a group of impaired elderly whose level of functioning did not in itself dictate either community-based or institutional care. The study focused on the question: What factors affect differential service usage in the presence of comparable impairment? The results indicated that the institutional group was more likely than their community counterparts to have had previous contact with other service providers, to be impaired in the area of mental health and to have less social resources and community support from family members or friends.

Vincente, L., Wiley, J., and Carrington, R.A. "The Risk of Institutionalization Before Death." *The Gerontologist*, 19, *4* (1979), 361-367.

The focus of this study was on the risk of institutionalization before death. The sample study consisted of 521 persons who were initially interviewed in 1965, and who died before January 1975. Successful reconstruction of long-term care histories was possible for 455 individuals. The analysis showed that poorer white people and females were more at risk of being institutionalized and that the number and availability of social supports significantly correlated with risk of institutionalization. The study results also showed a striking difference between rates of institutionalization among different age groups: Those in the 55-64 year-old age group--17.7 percent; those in the 85-or-older group--67.7 percent.

Barney, J.L. "The Prerogative of Choice in Long-Term Care." *The Gerontologist*, 17, *4* (1977), 309-314.

This paper summarizes two Detroit area studies which examined the circumstances associated with nursing home utilization. It also presents a ten-year agency experience in providing supportive services to the community-based elderly. The studies were prompted by an interest in preventing inappropriate institutionalization of long-term care patients. The first study which examined a nursing home patient population, addressed the need for assistance, the availability of financial resources, and the presence of social supports. The second study explored the question "could agency-based supportive services supplement or substitute for family and individual resources in preventing inappropriate institutionalization?"

Ward, R., Sherman, S., and La Gory, M. "Informal Networks and Knowledge of Services for Older Persons." *Journal of Gerontology*, 39, *2* (1984), 216-221.

Although members of informal support networks may refer family or friends to formal services, they may also reduce awareness of formal services by substituting for them. The authors of this study explored the association between informal ties and knowledge of service in a sample of 1,185 persons 60 years of age and over. The most common sources of information about services cited were relatively formal: media (T.V., radio, newspapers), senior citizen clubs, and social agencies. There was little evidence that informal network members were a source of information about services. Rather, knowledge of resources was found to be lower among those with high access or "strong ties" to children, confidants, and/or instrumental helpers.

Sample Discussion Questions and Issues

Copies of the articles can be made and one or two chosen to be distributed to training participants, or the articles can be assigned for reading in advance of the training session.

Does the experience of their clients coincide with the findings of the study? If sc, how? If not, what are the differences?

How might trainees alter their practice or intervention strategies based on the implications of the study results?

Do training participants agree or disagree with the findings of the study and their implication? How? On what basis?

What factors need to be taken into consideration when generalizing the results of a research study to practice?

Suggested Training Activity

Ask the training participants to design a research study to be conducted in their practice setting. Questions should focus on what they want to ask in order to obtain information that would be of use to them in service provision or treatment planning.

Human Behavior

The purpose of this unit is to delineate several concepts of human behavior useful to the human resource professional practicing in the long-term care arena.

With advanced age comes increased fraility and vulnerability to chronic disabling diseases. The delivery of appropriate long-term care services involves an understanding of both the specific impairments or conditions that can interfere with autonomous functioning and the biopsychosocial aspects of functional disabilities. Maslow (1968), a humanistic psychologist suggests that at every life stage fundamental needs must be satisfied before an individual is free to satisfy psychological and self-actualization needs. He developed a pyramid of human needs (see Appendix B to this module) placing at the base the fundamental requirements necessary to satisfy physiological needs (including food, water, and sex) and safety needs. At the next level of the pyramid identified by Maslow are belongingness, love and esteem needs. Finally, at the top of the pyramid, is the need to realize one's unique potential to the fullest--what he termed self-actualization. These basic life needs should be considered during the process of evaluating the client and in planning for the utilization of appropriate long-term care resources. This knowledge of human behavior can allow the human service worker to arrange for "quality care" service(s) most suitable to the client's level of functioning. (See Module 2 - Multifacted [Geriatric] Assessment.)

Regardless of their age or stage of life, people who find themselves in dependency-producing situations often experience a sense of vulnerability. Chronic health condition, illness or disease and the attendant need for care may exacerbate these feelings. The practitioner who understands and accepts the older adult's wish to continue to have a sense of control over his/her own life can address these feelings, and as a result will find that the client is better able to accept help.

Feelings of grief, anger, and despair often accompany the losses associated with marked reduction in physical mobility, sight and hearing impairments and loss of control of bodily functions that may precipitate the need for long-term care. In addition, impairments in functioning can cause the older person to lose valued roles associated with everyday tasks such as cooking, housekeeping and shopping. Eventually, impairments in functioning may result in the loss of living in one's own home or with family members.

Not only does the individual in these situations lose control over bodily and/or mental functioning, as a result of these limitations, living decisions and activities are removed from the person's control. One is put in a position of depending on someone else for perhaps the most basic of needs such as bathing to waiting for groceries or meals to be delivered. Adults who have been self-sufficient and even took care of others for years may have difficulty being dependent on others. For some individuals it is easier to depend on and accept care from relatives or friends that are known and trusted, while for others a more impersonal approach is more comfortable.

When making a treatment plan, practitioners' understanding of their clients' feeling can reinforce the utilization of the least restrictive services in the long-term care continuum in order to optimize individuals' own functioning.

In addition to understanding the impact and consequences of functional disbilities, practitioners who provide long-term care services should appreciate the cultural implications of age-specific behaviors (NASW Case Management Task Force, 1984). In a pluralistic society such as our own, people of diverse cultural backgrounds may perceive and report their experiences differently and may have different expectations and roles within the family. These differences can encompass help-seeking behavior(s) as well as methods of problem resolution (Greene, 1982).

However, what meaning an experience has for an individual and family should never be assumed because of cultural affiliation. There are as many differences within some cultural groups as among them. Degree of assimilation into the mainstream of society, geographic location of the family, etc., all influence traditional cultural values.

In order for practitioners to become more effective in working with different cultural groups, training should provide the opportunity for participants to learn cross-cultural communication skills (see Module 7 - Cross-Cultural Communication with Diverse Ethnic and Minority Elderly).

Most impared elderly continue to live outside institutions, receiving primary support and care from family members. The needs of family members, their attitudes, resources, etc., must be considered in the treatment plan. Care-giving systems, whether they be the family, a nursing home or day care center, are a form of social organization in which interpersonal relationships are structured and the division of practical tasks occurs. The practitioner who understands that "care is a truly collective action, depending upon direct and indirect contributions from a number of actors including the care for himself" (Daatland, 1983) is better prepared to work with the family and long-term care system of agency and community resources.

Families that assume the care-giving role may experience periods of disequilibrium as they attempt to respond to an illness of one of their members. Many new demands can shift a relatively balanced system of relationships into disequilibrium. The client's physical/mental condition and the effects it has on his/her functioning can directly affect family members who may be asked to make some changes and adjustments in their life to provide needed care. This can range from loss of time for leisure that is now spent on doing chores and errands to accommodating the client in their home and directly providing the care he/she needs. The practitioner who is alert to these difficulties can play an important role in relieving stress and restoring family functioning (see Module 3 - Intergenerational Family Dynamics).

Practitioners must also be aware of their own feeling about dependency and receiving care and of their personal preferences for the type of care they would be most comfortable accepting. Once their own feelings are identified and accepted, it is easier to separate them from their client's feelings and preferences, and the type of care and that may be inherently prescribed in the situation itself. The client's right to self-determination in making decisions and choices about the plans for his/her care should always be foremost in the mind of the human service worker. The work of the practitioner is not in making decisions or planning for the client, but in helping the client to plan, within the realities of his/her personal condition (including financial), family situation and the resources available. The practitioner also assists in implementing the plan into action.

Other community institutions, such as the nursing home, also can be viewed as caregiving systems. Advocacy is an important component of the practitioners' role. Within the nursing home system the human service professional may be able to act as intermediary among resident, family and staff to promote the best interest of the older adult receiving care there.

Human services professionals can advocate on behalf of individual clients as well as advocate for better practices and procedures on behalf of all clients in residence at a particular facility.

A systems approach can be equally valuable for practitioners working at community and state planning levels to promote programs, laws, and regulations that respect individual integrity and self-determination and provide long-term care services in a way that upholds the dignity of the individual, and helps persons in need of care to function at the highest level of their ability.

In short, human service professionals in long-term care deal with many types of systems. Among the most commonly encountered are the family, medical, social welfare, community, and political-economic systems. [The use of systems theory as an organizing and problem-solving tool can facilitate practice and the quality of care (see Berger & Federico, 1982, for a discussion of "Systems Thinking: An Integrating Tool").]

Sample Discussion Questions and Issues

The copy of Maslow's pyramid provided in Appendix A can be duplicated and distributed to training participants.

What do the training participants think about this conceptualization of human needs? Does everyone accept Maslow's theory? How does this conceptualization fit in with other theories of human development and behavior? How does it relate to human development theories about aging?

Ask the training participants to identify other theories on the psychology of human needs.

How can knowledge of Maslow's theory be used by the practitioner in evaluating the need for long-term care and helping the client plan for and obtain appropriate care?

Training participants can be asked to relate the hierarchy of needs to their own cases.

Training participants can be asked to identify how their clients feel about being dependent and accepting care provided by others.

Were these feelings considered in helping the client plan for long-term care? If so, how were they considered and what planning resulted? If not, should the client's feelings have been considered and why?

A case vignette, "Anne Freeman Was Seventy-Six, Sick and Alone," is provided in Appendix C. The case can be duplicated and distributed to training participants as a basis for discussion on the following:

--Dependency issues for clients in long-term care.
--The effects on family of the need for long-term care for a family member.
--The practitioner's own feeling about dependency, the need for care, loss of functioning, etc.

What are some other ways that one family member's need for long-term care can impact on the other family members individually? collectively? as a family system?

How does the need for care of one member affect family functioning, roles, relationships and interactions?

Identify ways through which the human service professional can assist a family to cope with a relative's need for long-term care.

Are families always willing to help, to provide support and direct care when necessary?

In situations where families are not available to provide care and support to a relative, what possible issues for the family and/or the individual client need to be addressed by the practitioner?

How might the practitioner go about helping the client and family deal with those issues?

Training participants can be asked to identify the cultural groups with which their clients are affiliated.

What culturally connected individual and family reactions have been observed to dependency and the need for care?

What implications did these culturally connected reactions have in planning for the use of long-term care resources?

Training participants can be asked to provide examples of situations in which they have acted as an advocate for an individual client, or where they have advocated within the agency, organizational, community or legislative system on behalf of a group of clients with similar situations.

Case Management

The purpose of this unit is to describe case management and to underscore its significance within the field of aging.

Definition

Case management is a flexible concept that encompasses clinical, administrative, and planning functions designed to fit specific client, agency and community needs.

"Case management is an approach to service delivery that attempts to ensure that clients with complex multiple problems and disabilities receive all the services they need in a timely and appropriate fashion" (Social Work Encyclopedia, 1987, p. 2).

Case Management in Long-Term Care

Case management is one of many client-centered professional activities appropriate within practice in the long-term care arena. It is the one most often associated with providing comprehensive, holistic, long-term care services. In actual practice, the coordination and delivery of services, as defined in the case management model, have been a traditional part of human service delivery. Mary Richmond (1922) was among the first to underscore the importance of the social environment and "indirect action" (p. 110).

Case management combines knowledge of human problems with responsibility for managing the service delivery system. Knowing who pays for what provided to whom under what circumstances allows the practitioner to assist people with problems and to find appropriate resources. In the provision of human services, both direct and indirect intervention strategies are utilized.

Case management requires an initial assessment of the person-problem-place situation, the delineation of specific goals and objectives designed to meet those goals. No one person can be "all things to all people," even though human service providers tend often to try. The role of the case manager must be made clear to the client. The case manager has overall responsibility to facilitate the case plan and acts as a resource broker to mobilize, coordinate and monitor services. Communication and information sharing with other service providers is essential.

The practice of care management, that is, those professional acts which are accomplished by the case management staff, whether government planner, administrator or caseworker, can be perceived to be of three levels: (1) the institutional or community level which involves conducting needs assessments, evaluating community support, determining agency responsibilities and program policies; (2) the interactional level which encompasses creating the inter-organization network of public and private services, linking the informal or natural helping networks such as community or religious groups, self-help organizations, etc., and conducting interpersonal or clinical tasks, and (3) the intra-personal level which includes evaluating intra-psychic factors as well as biological/physical conditions (Stumpf, 1981, p. 68). However, a practitioner may spend a proportion of time functiong at each of these levels in the conduct of his/her duties.

In addition to the care functions of case planning and monitoring, case management can include a wide range of functions from direct service provisions to service system evaluation. The variety of procedures and steps used in addition to the multiple functions performed are indicative of the generic nature of case management. Rather than focus on one or more specialized service such as family therapy, case managemnt involves knowledge of community resources, service systems and funding sources, client diagnosis and assessment, treatment planning and interagency and interdisciplinary collaboration. In the process of case management, attention is directed toward achieving specific goals through securing, maintaining and following through on service provision.

The roles of the case manager can also be viewed from a variety of perspectives: For the clinician case management is one form of psychosocial intervention, with specific functions related to assessment, goal setting, care plan implementation and review, and client advocacy. Responsibilities of the administrator, for whom case management is a means of providing a continuum of care for a target population, involve factors pertinent to quality assurance and documentation, financial management, contracting, and supervision. The program developer, uses case management as a device for designing a community-wide long-term care system, including techniques related to needs assessment and surveying, policy planning and social and political action (Steinberg & Carter, 1983, p.1; Strumpf, 1981).

The professional staff within the long-term care system assesses the individual in need of some kind of care, matching the level of impairment with the type of services rendered. This case management process, however, is more than the "pulling together" of concrete services. It involves the practitioner providing a source of emotional support to the elderly client and his/her family, and serving as a critical link among the client system and various community program and agencies.

As case managers, professionals will be involved in many critical issues, some of which may be discussed here. Among those that may be of concern is the lack of community resources or proper organizational structures and/or the need to work with other professionals. Also of primary interest is when to seek nursing home admission, and how best to help the older person and his/her family with this decision.

Case management programs generally include eight basic functions: 1) client identification and outreach, 2) individual and family assessment and diagnosis, 3) service planning and resource identification, 4) linking of clients to needed services, 5) service implementation and coordination, 6) monitoring of service delivery, 7) advocacy to obtain services, and 8) evaluation (Weil & Karls).

Innovation methods of outreach are always being sought when working with the present cohort of elderly who very often are reluctant to come forward for services. Participants should be encouraged to share information about outreach techniques that have worked for them. Assessment should be presented broadly and include an appraisal of : 1) the client's needs and resources available through the clients's informal supports, including family members, friends, and organizational memberships; 2) the impact of disability on the clients and the family; 3) the client's preexisting health or mental health problems; 4) the cultural implications of age-specfic behaviors and family functioning, the client's religious practices and values; 5) the system of formal community resources; and 6) the family's ability to assist the client, as well as to perform case management tasks on the client's behalf (NASW Standards, 1984). The assessment must be thought of in functional terms, addressing such basics as the client's ability to meet critical needs for food, shelter, and clothing as well as perform the activities of daily living (see Module #2).

Ideally, the professionals from a number of disciplines would be directly involved in assessment and in the subsequent development of a plan. In many instances, however, it is the case manager who has the responsibility. This requires the knowledge and skills to determine the client's level of functioning and an understanding of and ability to utilize community resources. In addition, the case manager should bring to this activity a recognition of client and family participation. All plans of care must have prioritized goals and measurable objectives. Trainers may want to consider what combination of modules and materials best offers the needed information and skill.

Implementation of the plan of care involves arranging for informal and formal services along a continuum of care. Among the skills required for this task are problem solving techniques to ensure continuity of services, relationship formation to maintain the trust of the client, and negotiation to overcome systems rigidity and fragmentation. Ongoing coordination and monitoring requires periodic reassessment of the client and the appropriateness of services. A critical factor becomes the case managers ability not to usurp the client's and the family's ability to do for themselves. Here trainers may want to explore participant's attitudes towards "promoting independence".

Because a wide range of services such as housing, income support, nutrition, transportation, education, information, legal services, etc. must be available to assist individuals in need of long term care, the person responsible for case management must have the necessary advocacy skills to obtain them. Teaching skills that allow participants to make their systems more responsive is therefore a must. Skills in data collection, working with citizen groups, and lobbying are only a few that come to mind.

Service evaluation, as we have seen in the section on research, is a critical case management program component. It is necessary for accountability to the consumer, to the funding source, and to the policy makers. Finally, like all professional practice, case management involves following basic ethical tenets, including recognition of the inherent worth and capacity of the individual and of his/her right to self-determination and confidentiality. Value clarification can be useful to foster participants ability to provide assistance in a nonobtrusive and supportive manner.

Sample Discussion Questions and Issues

Training participants can be asked what case management functions they perform and what part of their total job these activities comprise.

Depending on the level of the specific trainee group, an expert on community resources or benefit and funding sources can be invited to provide this information to participants. Trainees can also participate in sharing information about the resources with which they are familiar.

When obtaining and/or providing information about a client to service providers, what are the implications regarding client confidentiality?

After a referral for services is made and services are being provided, what mechanisms can be used to monitor the case, e.g., written reports, site visits, etc? What are the advantages of these monitoring mechanisms?

What possible problems could occur in the process of monitoring and coordinating a number of services from different providers?

Suggested Training Activities

These training suggestions are by no means all-inclusive, and depending upon the setting, any one professional may perform a variety of these different tasks. Therefore, it is important to keep the composition of the group in mind when establishing specific training goals.

Instructional materials included in this unit should reflect preregistration information on the needs and settings of the participants. Case examples, use of model forms, and educational methods pertinent to all settings and levels are available in "Case Management with the Frail Elderly: A Training Manual," a product of the Case Management Model Project Senior Care Action Network at Long Beach Area Geriatric Health Care Council, Inc., 1045 Atlantic Avenue, Suite 106, Long Beach, California 90813 (213) 436-2266.

Policy Issues

This unit outlines several long-term care issues that are related to both the design of service and the philosophy of care. These include:

- Recognition of the need for a continuum of planned, organized services within the financial reach of the older person and/or his family;
- Acknowledgement of the "right" of the client to individualized functional assessment as part of case management;
- Commitment to provide long-term care within the context of the family and other informal supports;
- Recognition of the need for a long-term care system which addresses both social and health needs.

Long-Term Care Policy

Efforts to formulate policies to address the health, social and personal care needs of individuals who have lost some capacity for self-care have been underway for more than two decades. Participants at the 1981 White House Conference on Aging expressed the need for an organized system of long-term care. They recommended that "public policy-makers fashion and demand an organized and coordinated delivery system of long-term care that fully recognizes both social and health needs" (Report of the Technical Committee on Social & Health Aspects of Long-Term Care, 1981).

In addition, the 1981 White House Conference called for each community to have a publicly sanctioned long-term care system that would provide for:

> person-focused case management with the capacity to assess need, determine eligibility, provide linkage for those in need of formal services and assist the person in his or her informal support system (Report of Technical Committee on Social and Health Aspects of Long-Term Care, 1981, p.11).

The conceptualization of a long-term care system focuses on the rights of the individual, and the enhancement of his/her social functioning. This philosophy can be used as a basis for policy-making decisions, program planning and social action for practitioners performing various functions in diverse locales and settings.

While the problem of providing comprehensive care may not be resolved until well into the next century, there are several new and emerging program and policy developments in long-term care with which practitioners should become familiar. Approximently thirty states now have some initiative underway in the area of long-term care, many of which are supported with funding from the Health Care Financing Administration and by the Administration on Aging. These demonstration projects represent an effort to restructure public medical care financing so as to provide a larger financial base for community-based long-term care and to eliminate the bias towards institutional care (Bechill, 1984). While there are a number of alternative models now in use for coordinating and finalizing long-term care systems the following have been chosen for discussion. (For further models see Callahan, J.J. and Wallack, S.S. Reforming the Long-Term Care System: Financial and Organizational Options. Lexington, MA. Lexington Books, 1981).

(1) The Channeling Brokerage Model - The Monroe County (New York) Long-Term Care Program, Inc. (ACCESS) which was incorporated as a nonprofit organization in 1976, is designed to serve adults at risk and features a single entry system. Programs such as these provide a centralized comprehensive evaluation, referral to a wide range of long-term care services, and regular reassessment. They rely on existing service providers and the efforts of a case manager/advocate to coordinate and link services on behalf of the frail older person. ACCESS uses the case management team, consisting of professional nurses, medical and psychiatric social worker, and clerical support, to assess the client and to obtain care in the "most independent, least restrictive setting" (see Eggert, Bowlyow, & Nichols, 1980, for a full description).

(2) The Consolidated Model - The ONLok Health Services is a nonprofit, community-based organization in the Chinatown-North Beach area of San Francisco which operates a Community Care organization for Dependent Adults (CCODA). It is an example of the consolidated approach in which a single service system is established to provide directly all needed services. The CCODA differs from traditional services by (a) providing the full range of social and medical services in a single integrated health program, (b) delivering services through the same professionals who plan them, (c) funding all services through a single source (Medicare), and (d) providing implicit financial incentive to control cost (see Zawadski & Ansak, 1983 for a full description of the program).

During the last five years, ten states have been experimenting with new designs for long-term care systems. Florida, Kentucky, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas are engaged in the National Long-Term Channeling Program. The data and outcomes from these demonstration programs should soon be available and may provide considerable information for discussion, if not fuel for future policy debate and program planning.

Sample Discussion Questions and Issues

For a basis of discussion of an innovative policy option see Arling & McAuley, 1983, on "The Feasibility of Public Payments for Family Caregiving," a study based on data collected from the Statewide Survey of Older Virginians funded by the Virginia Department of Welfare and the Virginia Office on Aging.

Trainers can also select for discussion programs in their region that offer examples of new ideas for a more comprehensive client-focused long-term care system.

What is the applicability of these examples to other settings?

Suggested Training Activities

Training participants can be divided into groups in which they are to design a community-based long-term care service system. These plans would then be presented to the full training group for discussion.

How would these service systems address the current problems encountered in obtaining appropriate services for clients?

What would the next steps be in promoting such a plan in the local community? At the state level?

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Austin, C. "Case Management in Long-Term Care: Options and Opportunities." *Health and Social Work*, 1983, pp. 16-30.

This article discusses case management as a tool to reform the long-term care delivery service system based on the authority of the case manager to allocate services. The extent to which the case manager has authority for allocation can affect his/her capacity to act as change agent in the local system. The author proposes that case management can be used as a strategy for altering the market behavior of providers, and for shaping the character of systems for the delivery of long-term care. She also suggests that guidelines for such a strategy can be found in the resource dependence theory of interorganizational relationships which is discussed in the article.

Debrof, R., and Letwok, E. "Maintenance of Family Ties of Long-Term Care Patients: Theory and Guide to Practice." U.S. Department of HEW. NO (ADM) 79-400, U.S. Government Printing Office, 1977 and 1979.

These authors offer a positive and practical view of working with the family and nursing home staff on behalf of the elderly patient. There are many useful suggestions for enhancing these interrelationships. At the same time the authors remind us that there are some residents who enter a nursing home "with a long history of family pathology and a relationship characterized by feelings of anger, abandonment, guilt and grief. Visits may be few and far between." They suggest that the social worker accept this fact, encourage families to participate at "a proper distance," and work with staff to fill certain personal needs.

Getzel, G.S., and Mellor, M.J., eds. *Gerontological Social Work Practice in Long-Term Care*. New York: The Haworth Press, 1982

This reader (actually Journal of Gerontological Social Work, 5, *1/2* [Fall/Winter 1982]) is a compliation of articles related to social work in long-term care. The selection encompasses practice in adult day care, hospitals, rehabilitation centers, nursing homes, and community-based practice. It deals with such issues as death and dying, natural support programs and the minority aged.

Hayslip, B., Ritter, M.R., Oltman, R., and McDonnell, C. "Home Care Services and the Rural Elderly." *The Gerontologist*, 20, *2* (1980), 192-199.

This article reports on two independent studies which examined a needs versus agency perspective on home health care services within a primarily rural county. Interviews with 299 elderly aged 60 to 93, revealed that the desire for services varied with residence within the county. Agency data suggested that service delivery was not based on population distribution and that income, service accessibility, service visability, interagency coordination and staff priorities were factors affecting the quality and quantity of service.

Jorgensen, L., and Kane, R. "Social Work in the Nursing Home: A Need and an Opportunity." *Social Work in Health Care*, 1, *4* (Summer 1976), 471-482.

This article reports the results of a Nursing Home Demonstration Project developed by the Department of Community and Family Medicine of the University of Utah College of Medicine. The project was designed to test the cost-effectivenesss of the nurse clinician in the primary care role, and also investigated the use of social work services. The authors concluded that the patient's levels of functioning and behavior were improved through social work interventions. Specific administrative, educational, and practice skills are defined.

Kane, R.L., and Kane, R.A. "Alternatives to Institutional Care of the Elderly: Beyond the Dichotomy." *The Gerontologist*, 20, *3* (1980), 249-259.

The seemingly inevitable growth in the demand for long-term care services and accompanying cost implications have spurred strong interest in seeking alternatives to nursing homes. The rationale for such alternatives, according to the authors is a mixture of prevention, displacement and deinstitutionalization. The authors go on to say that none of these things may result and that alternative services may prove to be additive rather than substitutive. Much research is needed to provide the basis for examining the variety of proposed alternatives to allow for the comparison of costs and benefits in some reasonable fashion.

McDonald, M., and Settin, J. "Reality Orientation Versus Sheltered Workshops as Treatment for the Institutionalized Aging." *Journal of Gerontology*, 33, *3* (1978), 416-421.

The authors who are interested in psychosocial programs for the institutionalized elderly, examine the use of sheltered workshops relative to reality orientation in a nursing home. The authors found that sheltered workshops were more successful in improving measures of life satisfaction and social interest.

National Association of Social Workers. Case Management Task Force. "NASW Standards and Guidelines for Social Work Case Management for the Functionally Impaired." Washington, D.C.: National Association of Social Workers, 1984-85.

These standards and guidelines are addresssed to those social workers in a case management function in long-term care programs. It recognizes case management as a process within the traditional framework of generic social work practice, and makes suggestions from an ethical and a practice point of view. Case management as a shared function, specific case management tasks, accountability and program evaluation, and resource development and social action are also addressed.

National Association of Social Workers. Committee on Aging. *Long-Term Care for the Elderly, Chronically Ill and Disabled*. Washington, D.C.: NASW, 1979.

This position paper provides an overview of issues in long-term care including problems and recent developments. The committee recommends that long-term care systems "must move from a medically-orientated, custodial model (poorly designed to provide the social services and rehabilitation required) toward a system designed to help the aging remain as healthy as possible and to live in their own homes as long as possible."

Noelker, L., and Harel, Z. "Predictors of Well-Being and Survival Among Institutionalized Aged." The Gerontologist, 18, 6 (1978), 562-567.

This research sought to ascertain predictors of well-being and survival among residents in long-term care facilities. Analysis of initial interview and two-year follow-up data showed that primary predictors of morale, life satisfaction, satisfaction with treatment and survival were residents' subjective perceptions of the facility, and their preference about living in it or elsewhere. Findings indicate more careful attention must be given to residents' cognitive and emotional states at the application and entry stages as well as throughout their residence.

Palmore, E. "Total Chance of Institutionalization Among the Aged." The Gerontologist, 16, 6 (1976), 504-507.

This article presents the results of a twenty-year longitudinal study of 207 elderly persons and found that their total chance of institutionalization sometime before death was about one in four. Factors increasing the need for institutionalization were living alone, being never married or being separated, having no or few children, and being female. Factors increasing access to institutions were adequate finances, education, and being white. In contrast to the prevalence rate, total chance of institutionalization does not increase with age.

Snyder, L. H., Rupprecht, P., Pyrek, J., Brekhus, S., and Moss, T. "Wandering." The Gerontologist, 18, 3 (1978), 272-280.

Inasmuch as institutions such as nursing homes assume a moral and legal responsibility to protect patients, they may use devices such as body holders, "pharmacological restraints," door locks, geriatric wheelchairs, etc., to prevent patients from wandering. The authors did a study of wandering behavior in an effort to find humane and safe methods of management. They discuss types of wandering behavior, psychosocial issues and strategies for working with wanderers.

Steinberg, R.M., and Carter, G.W. Case Management and the Elderly. Lexington, MA: Lexington Books, D.C. Heath Co., 1983.

The purpose of this book is to present the subject of case management with the frail elderly from the perspective of the planner, the administrator, and the evaluator. It deals with a variety of components of program designs that are "mixed and matched" to suit particular purposes in particular environments from a research perspective. Guidelines and recommendations for the development, implementation and evaluation of case-coordination programs for the elderly were formulated as the major product of the research.

Stumpf, J. "Case Management with the Frail Elderly. A Training Manual." California: Senior Care Action Network SCAN and Los Angles County Dept. of Senior Citizens Affairs, Area Agency on Aging, 1981.

This training manual is a guide to learning case management for the frail elderly for those who wish to create a case management program and have had little or no prior experience. It presents knowledge, information, and skills in direct service, community work and organizational management. It presents such useful materials as a Needs Assessment Form, Informed Consent Form, Form for Case Presentations, Purchase of Services Agreement, Interagency Agreement, Monthly Service Summary, and Transportation Voucher Order. The volume is so designed that a comprehensive service could be established using it as a guide.

Tobin, S., ed. *Current Gerontology: Long-Term Care*. Washington, D.C.: Gerontological Society of America, 1982.

This is the first volume of the *Current Gerontology*, a monograph series comprised of articles taken from the *Journal of Gerontology* and *The Gerontologist*. It provides an overview of the many issues associated with long-term care and is divided into three sections:

1. General issues;
2. Treatment perspectives; and
3. Policy considerations.

United States General Accounting Office. *Entering a Nursing Home--Costly Implications for Medicaid and the Elderly*. November 26, 1979. PAD-80-12, p. 9.

This publication discusses the relative costs of Home Health Care versus Nursing Home Care. It reports that most elderly (Florida residents) prefer living in their own home. Nursing home placement is feared because of loss of independence and community ties.

Valdeck, B.C. *Unloving Care: The Nursing Home Tragedy*. New York: Basic Books, 1980.

This book is about public policy and the dilemmas faced by government when it purchases nursing home care for public program beneficiaries. The author offers little hope that nursing homes can be reformed to offer quality care, and makes concrete proposals for systematic changes in the way the U.S. handles long-term care. For a review, see B. Dunlop, *The Gerontologist*, 20. *6* (1980), 621-625.

Weil, M. and Karls, J. M., *Case Management in Human Service Practice*. San Francisco, California: Jossey-Bass Inc. Publishers, 1985.

This comprehensive text discusses case management from the point of view of the clinician as well as the administrator. It provides an excellent grounding in the principles and components underlying effective case management and discusses how these can be applied in working with a variety of populations including the elderly. It is a valuable resource for human service providers who want to learn more about containing costs, improving accountability, making better use of existing resources and services, encouraging better communication and cooperation among service providers, enhancing decision making, and eliminating waste caused by duplicating services.

White House Conference on Aging. *Report of the Mini-Conference on Long-Term Care*. Washington, D.C.: Department of Health and Human Services, 1981.

The purpose of the mini-conference on long-term care was to try to provide policy direction and to encourage activity to strengthen community-based long-term care to meet individual needs. The delegates make recommendations for community planning at the local, state and national levels that will lead to the coordination and interaction of health, social and voluntary and community services.

________. *Report of the Technical Committee on Social and Health Aspects of Long-Term Care*. Washington, D.C.: Department of Health and Human Services, 1981.

This report recognizes and discusses the critical role of the family in providing the "vast bulk of care received by functionally disabled persons." It calls for public policy which will enhance and supplement this effort, calling for tax incentives. It calls for each community to have a publicly sanctioned long-term care system which provides for "person-focused case management with the capacity to assess need, determine eligibility, provide linkages for those in need of formal services and assist the person in his or her informal support system" (p. 11).

York, J.L., and Calsyn, R. J. "Family Involvement in Nursing Homes." *The Gerontologist*, 17, 6 (1977), 500-505.

This study was undertaken in order to study some of the factors that affect family involvement in nursing home care. Variables examined were: (1) family involvement prior to nursing home placement; (2) factors leading to the decision to place the patient in the nursing home; (3) quantity and quality of home visits to the patient after placement in the nursing home; (4) willingness of families to participate in various educational and therapeutic programs; (5) level of support families receive from physicians and nursing home staff; and (6) mental and physical status of the patients. The results indicated that there was continued involvement of families. This was considered to be a powerful treatment resource by the researchers who make suggestions for increasing family involvement.

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AUDIOVISUAL RESOURCES

Slide-tape: Let's Keep Mrs. Gordon In Her Home
15 min., 1980.

(Contact: Dr. Sherry L. Berkman
School of Social Work
California State University
at Long Beach
1250 Bellflower Blvd.
Long Beach, CA 90840)

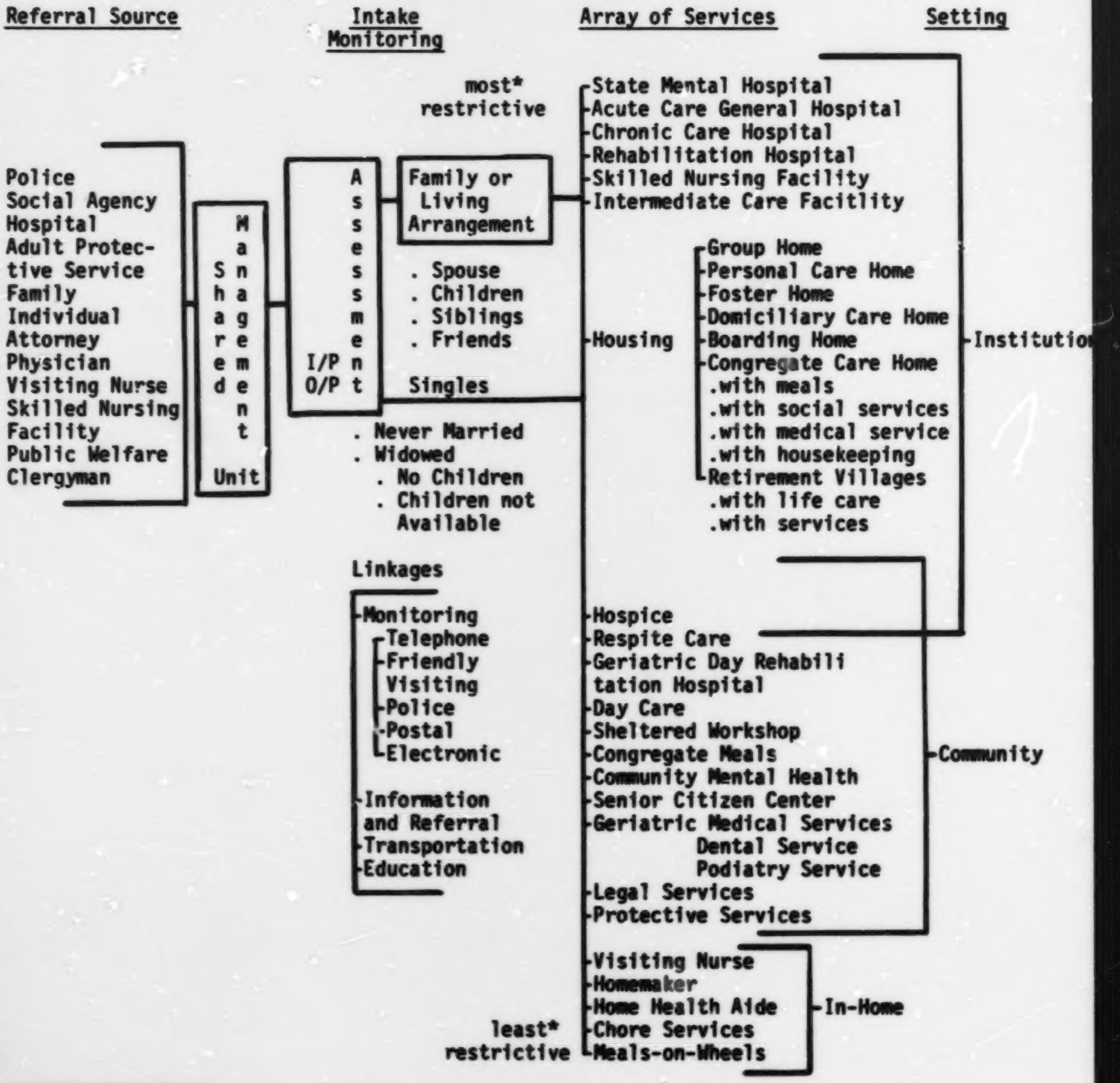
Dramatizes the case of an elderly woman who is able to remain at home because of the in-home services provided by the community.

Film: What Shall We Do About Mother?
49 min.

This documentary shows the heartbreak of two families: both consist of hard-working middle class citizens too financially secure for public assistance, but unable to afford private nursing homes. Often, the middle-aged children of aging parents suffer from feelings of resentment and guilt, as well as financial strain, when forced to care for their parents at home.

APPENDIX A

Long-Term Support System


Referral Source
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Police
Social Agency
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Adult Protective Service
Family
Individual
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Physician
Visiting Nurse
Skilled Nursing Facility
Public Welfare
Clergyman
Shared Management Unit
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Family or Living Arrangement
. Spouse
. Children
. Siblings
. Friends
Singles
. Never Married
. Widowed
. No Children
. Children not Available
Linkages
Monitoring
Telephone
Friendly Visiting
Police
Postal
Electronic
Information and Referral
Transportation
Education
State Mental Hospital
Acute Care General Hospital
Chronic Care Hospital
Rehabilitation Hospital
Skilled Nursing Facility
Intermediate Care Facitlity
Housing
Group Home
Personal Care Home
Foster Home
Domiciliary Care Home
Boarding Home
Congregate Care Home
.with meals
.with social services
.with medical service
.with housekeeping
Retirement Villages
.with life care
.with services
Institutio
Hospice
Respite Care
Geriatric Day Rehabilitation Hospital
Day Care
Sheltered Workshop
Congregate Meals
Community Mental Health
Senior Citizen Center
Geriatric Medical Services
Dental Service
Podiatry Service
Legal Services
Protective Services
Community
Visiting Nurse
Homemaker
Home Health Aide
Chore Services
Meals-on-Wheels
In-Home
least*
restrictive

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* The classification of from most to least restrictive is a general view of services and may vary within each service.

Source: "Data for Long-Term Care Planning by Health Systems Agencies" by S. J. Brody and C. Masciocchi in Journal of the American Health Association, Volume 70, No. 11, pp. 1194-1198.

APPENDIX B

Maslow's Pyramid of Human Needs

The need to fulfill one's unique potential	Self-Actualization Needs
Esteem needs: to achieve, be competent, gain approval and recognition	Psychological Needs
Belongingness and love needs: to affiliate with others; to be accepted and belong	
Safety Needs: to feel secure, safe and out of danger	Fundamental Needs
Physiological needs to satisfy hunger, thirst and sex drives	

APPENDIX C

Case Vignette:
Anne Freeman Was Seventy-Six, Sick, and Alone

"I don't know, Mary. I suppose some people would say I wasn't accepting this real well. But - not even able to get out of bed! Me, of all people! Why, I can't even control..." Miss Freeman's voice trailed off, and she lay quietly, looking out of the window of her stone cabin in the California hills. Miss Anne Freeman was 76, and for the last 25 years she had lived alone in this modest cabin, without hot water, without a refrigerator, washing machine, or even a telephone. She had had a spectacular view, her painting and her needlework, and most important, she had had her privacy. Now her body was revolting against her. She was about to lose everything, the cabin, the hills, and her privacy.

Ms. Mary Sanders, the woman to whom Miss Freeman had been talking, was a social worker with almost forty years of professional experience. From their first meeting, Miss Freeman had insisted on calling her "Mary," she seemed to pretend that "Mary's" visits were completly social and had nothing to do with her professional capacity. Ms. Sanders certainly hadn't objected; many of her clients called her by her first name, and Ms. Sanders was close enough to Miss Freeman's age that she could imagine some of what she was going through.

Besides, in at least one way, her visits no longer had much to do with her professional capacity. Ms. Sanders worked for the Regional Domiciliary Care Service, and for 38 years she had tried to do everything she could to make it possible for elderly people to stay in their homes. That was why she had originally come to see Miss Freeman. But this time it would have to be a losing effort. Miss Freeman needed too much care; the family couldn't provide it; and she had only a small pension coming in. She would be forced to go into a home, and she would see that for herself before much longer. When the time came, Ms. Sanders knew, the problem wouldn't be in convincing her to go but in helping her to maintain her pride and her dignity.

Ms. Sanders had noted that Miss Freeman hadn't been able to finish her last sentence. She hadn't been able to say out loud that she was losing control of her own bowels. Her chronic diarrhea and the loss of control were being caused by a fiscula, for which nothing could be done. She also suffered urinary incontinence because of a vesico-vaginal fiscula. In the past two months, she had required three transfusions to treat her anemia. All of these problems were related to a cancer of the uterus which had been originally diagnosed six years before. Miss Freeman had received radiotherapy then, and the doctors were not now sure of the state of the cancer, but Miss Freeman realized that the prognosis for the long-term couldn't be good. She was ready--perhaps too ready--to die, but this wasn't the death she would have chosen. She could endure the pain, which would be considerable, but this was so debilitating, so humiliating, and it made her so utterly dependent on others.

When Ms. Sanders had first met her, Miss Freeman hadn't wanted to depend on anyone. She had asked her niece to contact the Domiciliary Care Service because she was having trouble getting on and off the toilet and in and out of chairs by herself. She had heard that the Service could provide, as she put it, "some sort of chair blocks and toilet raisers, or something--sounds like block and tackles or something to lift furniture to me--but if it'll help me to get around my place, I'll take 'em!" Ms. Sanders had made sure that Miss Freeman got what she needed, and, at the time, that kind of help with the cottage had been all she had needed.

Soon, however, Miss Freeman was receiving other help. She reluctantly agreed, at the urging of her niece, to accept Meals on Wheels. "I can cook well enough, I suppose," she had said, "but it is kind of hard when you don't have a refrigerator. I can't walk into town to shop everyday, like I used to." She often ended feeding the meals to the birds--they were "tasteless" she said--and living off of the pastries and cookies her niece brought her, along with some fresh fruit.

This niece, Mrs. Joanna Perry, had been Miss Freeman's primary emotional support for some time. She had visited her daily for years, and her sons helped with chores. Since Miss Freeman's last series of medical set-backs, Mrs. Perry had been forced to do more and more for her aunt. When Miss Freeman finally reached a point where she could no longer get herself out of bed in the mornings, she refused an offer from a volunteer nursing agency to send someone to help her every morning; she insisted that her niece drive out from town each morning, get her up for the day and cook her breakfast, all before she had to return home and get her four sons off to school and herself off to work. Mrs. Perry had also begun to do all of her aunt's washing.

Despite all her niece did for her, Miss Freeman showed little affection toward her. She seemed to view the help her niece offered as her "due;" she had raised her niece's father and their other three younger brothers after their parents had died when she was fifteen. She had stayed at home and not gone to art school. To her, her niece's help was like having a loan paid back.

In fact, Miss Freeman hadn't generally shown much affection towards anyone. Throughout her life, she had demonstrated an independence that bordered on rudeness. There had been an unpleasant situation when Miss Freeman had decided that a Meals on Wheels volunteer was "prying into her private affairs." Miss Freeman has always enjoyed the remoteness of her cottage; she had few friends, and she didn't want any more than she had. Besides her niece and Ms. Sanders, the only person who had visited the cottage in years was the woman who had come up from the local craft store to collect Miss Freeman's paintings and quilts to sell. She hadn't come in months, and Miss Freeman had stopped mentioning her.

Yet despite Miss Freeman's aloofness and general independence, there were signs that she became overly-demanding and overly-dependent once she lost control of the situation. Ms. Sanders discovered, while talking to Mrs. Perry, that six years before, when Miss Freeman's cancer was first diagnosed, she had been given a colostomy. She was very depressed about that condition and refused to eat unless she was hand-fed by her niece. The stoma had abscessed and needed multiple dressings daily, but Miss Freeman would allow no one but her niece to do that, either.

After the colostomy had closed, Miss Freeman had resumed her normal, independent life, living in her cottage in the hills, painting and staying away from people. But now it was all coming back, the disease, the depression, the revulsion with her own body, even the growing dependence on her niece. This time it was going to be much worse. She was going to need constant care, and her niece couldn't possibly leave her job. A nursing home seemed to be the only option, and Miss Freeman seemed to be beginning to see that. Only three months ago she had refused to consider it. Two months ago she had been willing to talk about it. Last month she had applied to a local Methodist home.

"Oh, Anne will go all right," Ms. Sanders thought as she looked at the thin figure on the bed. "She won't have much choice, will she? But how do I make her feel all right about it? How do I make a woman like her see that it's okay to let other people help you? And how, in the little time that's left, do I help her to accept what's happening to her body?"

And, as Mary Sanders go up to leave, she looked at Anne Freeman once more and realized there was one more question she needed to start asking herself. "How do I deal with myself when I find out I can't make it all right for her?"

****

Authorship of Vignette: Mary G. Schmidt
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CROSS-CULTURAL COMMUNICATIONS WITH DIVERSE ETHNIC AND MINORITY ELDERLY

This unit focuses on cross-cultural communications and is designed to assist practitioners to utilize ethnographic information in providing culturally sensitive social services. The goals are to explore individual and institutional impediments to effective service to minority clients, and to identify professional issues and strategies to eliminate discrimination in service delivery.

The purposes of this module are to:

- Examine how cultural differences and/or minority status can impact the lives of older clients, and the types of service exhibited needs and treatment approaches utilized;
- Present specific theoretical frameworks to improve cross-cultural understanding and enhance cross-cultural communication;
- Raise questions about professional commitment and agency policies and their effect on the provision and availability of culturally relevant services;
- Offer exercises to heighten self-awareness of personal attitudes towards cultural diversity.

The learning objectives of this module are to:

- Increase knowledge of the societal influences affecting minority clients;
- Identify ways in which culture influences a client's help-seeking behaviors;
- Increase recognition of the impact of cultural factors on the client's perceptions of the problem;
- Increase knowledge of culturally relevant problem-solving strategies and the use of "natural helpers" in working with culturally diverse groups;
- Demonstrate skill in eliciting the client's ideas of the nature of the problem, and possible solutions to it;
- Increase knowledge of interviewing, assessment, and treatment issues related to cultural diversity.

The Parameters of Cross-Cultural Practice

The purpose of this section is to discuss the helping process from a cross-cultural perspective, with emphasis on the impact of culture, ethnicity, and minority group status on help-seeking behaviors and service utilization.

Definitions

> An ethnic group consists of those who conceive of themselves as being alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others (Shibutani & Kwan, 1965).
>
> Members of an ethnic group have a sense of a shared past and similar origins. They also believe themselves to be distinctive from others in some significant way. This is most important at times when members of differing groups are in contact (Green, 1982, p. 9).
>
> Culture refers to the way of life followed by the group. Culture is that which binds a particular society together and includes its manners, morals, tools, and techniques (Anderson & Carter, 1974).
>
> Culture embodies the values, knowledge, and material technology that people learn to see as appropriate and desirable. Therefore, culture establishes the parameters that guide and often limit thinking and behavior (Berger & Federico, 1982, p. 10).
>
> Culture can be thought of as those elements of a people's history, tradition, values, and social organization that become implicitly or explicitly meaningful to the participants during an encounter (Greene, 1982).
>
> Culture may also be thought of as what is known and shared by the members of a group as their collective "cognitive map" of reality or as the behavior and customs (of a group) and their transmission from generation to generation (Greene, 1982).
>
> Culture is made up of those things which are relevant to communication across some kind of social boundary (Green, 1982, pp. 6-7).
>
> Culture refers to the fact that human groups are distinguishable by the manner in which they guide and structure behavior, and the meaning ascribed. Cultures differ in their world view, in their perspectives on the rhythms and patterns of life, and in their concept of the essential nature of the human condition (Devore & Schlesinger, 1981, p. 9).

Minority standing refers to power, not numbers, and the degree to which the individuals who are identified with some group may be denied access to privileges and opportunities available to others (Green, 1982, p. 7).

Minority groups are "the underprivileged in a system of ethnic stratification and people of low standing--people who receive unequal treatment and who therefore come to regard themselves as objects of discrimination" (Shibutani & Kwan, 1965).

The term minority group is used to refer not only to frequency or numbers but also to the "objective and subjective features of a group, and of its way of fitting into the social setting" (Streib, 1968, p. 35).

A minority is a group of people who, because of their physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination (Wirth, 1945, p. 347).

Those groups that have unequal access to power, that are considered in some way unworthy of sharing power equally, and that are stigmatized in terms of assumed inferior traits or characteristics are minority groups (Mindel & Habenstein, 1976).

The Encyclopedia of Social Work designates Native American Indians, Asian/Pacific Americans, Black Americans, Chicano Americans, and Puerto Rican Americans as minority groups.

Sample Discussion Questions and Issues

What do the definitions have in common?

How do these definitions compare to how particular minority groups would define themselves?

Practice Issues Related to Culturally Diverse Populations

While it is usually taken for granted that the process of aging has its psychological, biological and social dimensions, practitioners must also be aware of the role of cultural factors in actual service delivery. This section focuses on the range of practice issues that pertain to ethnic and culturally diverse populations and on ways to improve cross-cultural communications.

"Social gerontology literature includes various definitions for the minority elderly based on characteristics of race, national origin, and sex" (Soniat, 1982). First a distinction should be made between a minority and an ethnic group. Members of an ethnic group consider themselves to be alike, having a sense of shared past and similar origins, and are so regarded by others. This sense of being distinct from others is most important at times when members of differing groups are in contact or "cross ethnic boundaries" (Green, 1982). Minority group members also share a unique history, one that is characterized by discrimination resulting in unequal access to resources, influence and power in the social structure.

Ethnic and minority elderly consist of many subgroups with diverse life styles, histories, and cultural strengths and supports. These cultural patterns affect help-seeking behaviors and the perception and utilization of services.

A premise of cross-cultural human service practice is based on the assumption that American society is culturally diverse and efforts must be made to see each client as an individual with a unique history and perspective in large measure stemming from the values and norms of their racial/ethnic group of origin. Acquiring accurate knowledge about how the client perceives his/her life situation and problems within that individual's cultural context is an essential component of problem identification and problem solving. Minority groups should be understood not only in the context of the problems that often accompany their minority status, but for the richness of their heritage and the benefits they can give to society (Soneat, 1982). Understanding the elderly in the context of their culture can provide the practitioner with clues about coping mechanisms, strengths and means of adaptation.

"Cross-cultural social work is the utilization of ethnographic information in the planning, delivery, and evaluation of social services for minority and ethnic group clients" (Green, 1982, p. 49). From this point of view, practice with minority and ethnically diverse clients involves adequate preparation for and alertness to cultural background factors that affect "social service encounters." This is a complex process involving self-awareness, values, attitudes and receptivity to carry out diagnosis and service provision with recognition of the client's cultural integrity.

Culture is a powerful influence on behavior, and encompasses the values, knowledge and resources that people learn to see as appropriate and desirable. Culture establishes the parameters that guide and often limit or structure thinking and behavior (Berger & Federico, p. 10).

Because cultural norms and values are group-specific, the practitioner engaged in cross-cultural communication must be cognizant of social boundaries, and be prepared to move beyond the limits/bounds of his/her own personal experiences. The practitioner must make a conscious effort to help the client in a manner that is congruent with the client's cultural values and attitudes, regardless of whether or not the practitioner shares or agrees with them.

Research on Cultural Diversity and Ethnicity

In this unit research studies on ethnic and minority aged are reviewed and their implications for practice are examined. Some of the theoretical and conceptual difficulties with this literature are outlined.

There are several limitations associated with the literature on ethnic and minority elderly. Until recently, most gerontological research has been based on limited samples (white middle-class subjects) from which generalizations have been made. As a result, there is insufficient information about the differing cultural patterns and life styles of the minority and ethnically diverse aged, and little understanding of how ethnicity and/or minority group status may impact on the aging process.

Another weakness with the minority and ethnic group literature is that investigators often fail to take into account the heterogeneity of ethnic populations. Such an approach often "subsumes culture under the exigencies of social class," assuming comparability among members of an ethnic or minority group just because they share group membership (Holzberg, 1982, p. 251). When planning and delivering services to the elderly, the impact of cultural diversity must be taken into account, as well as the variations in cultural patterns both between and within ethnic groups.

In order for the available research to provide useful information to guide practice with the elderly among ethnically diverse and minority populations, it must offer a realistic view of cultural dynamics as these may affect the aging process. This type of research can assist policy makers and practitioners to plan and provide "ethnic-sensitive" services (Devore & Schlesinger, 1981). Unfortunately, too many studies of the aging process do not take into account ethnic and minority factors. Bias may be built into some studies, e.g., situational factors, such as poor housing, low income, and overcrowding often brought about by years of discrimination, may erroneously be treated as the operational or "given" features of the group's culture. In such instances, investigators fail to identify and account for critical cultural patterns, customs, and interactional networks.

The following studies have been chosen for use in this section because of their positive contribution to understanding minority and ethnic aged.

Dowd, J.J., and Bengtson, V.L. "Aging in Minority Populations: An Examination of the Double Jeopardy Hypothesis." Journal of Gerontology 33, 3 (1978): 427-436.

The plight of minority aged has been characterized by many as one of double jeopardy: in addition to the disadvantages imposed by their minority group status, the minority aged are said also to experience the devaluation in status associated with old age in our society. The authors, who were aware of research that indicated that gaps between minority and majority individuals tend to decline with age, wanted to test these seemingly competing hypotheses. They sampled 1,269 middle-aged and older blacks, Mexican-Americans, and whites in Los Angeles county on such variables as health, income, life satisfactions, and social participation. It was found that differences among the three ethnic groups do exist, and in some cases, particularly on income and self-assessed health, constitute a case of double jeopardy for the minority aged. The data also suggest that age exerts a leveling effect. The authors concluded that consideration should be given to the variation in personal and social situations of the aged both across ethnic boundaries and within ethnic categories.

Gelfand, D.E., and Fandetti, D.V. "Suburban and Urban White Ethnics: Attitudes Towards Care of the Aged." The Gerontologist 20, 5 (1980): 588-594.

This article examines the results of a project studying attitudes towards care of aged family members among a sample of middle-aged Italian-American males living in the suburban "Newtown" of Columbia, Maryland. The attitudes of Columbia Italians are compared with those of working-class Italian and Polish residents in an inner-city Baltimore neighborhood. The authors concluded that while the family and Catholic Church remained important sources of preferred support, increased willingness to utilize institutional forms of long-term care was noted among the Columbia, Maryland group.

Hanson, S., Sauer, W.J., and Seelbach, W.C. "Racial and Cohort Variations in Filial Responsibility Norms." The Gerontologist 23, 6 (1983): 626-631.

Most previous research has taken a cultural relativistic approach in studying the black family which depicted them as having a "unique structure and style" (Billingsley, 1970). This present study focuses on racial variations in norms regarding filial responsibility. These norms refer to the obligations of adult children to meet the needs of aged parents. Age and cohort differences are explored in a sample of 339 black and 1,611 white respondents. Repondents are asked to answer "agree," "disagree," or "undecided" to five questions concerning their willingness to assist parents. Chi-square analyses and zero-order correlations revealed that whites were significantly more likely than blacks to support filial responsibility statements on all five norms. However, in general, filial responsibility norms were not endorsed by a majority of all respondents, thus leading the authors to conclude that philosophically respondents believe in independence and autonomy on the part of both middle-aged children and their aging parents. The authors question whether there would be such differences in filial responsibility if they studied the amount of actual supportive behavior rather than agreement with stated norms.

Wolf, J.H., Breslau, N., Ford, A., Ziegler, H., and Ward, A. "Distance and Contacts: Interactions of Black Urban Elderly Adults with Family and Friends." Journal of Gerontology 38, 4 (1983): 465-471.

These authors state that distance is the major factor determining the frequency of social interaction with family and friends for elderly whites. Age, sex, marital status, length of residence, and income also affect the number of social contacts. These relationships had not been previously studied for elderly blacks. This analysis concentrates on identifying the social contacts of black elderly individuals with family and friends outside their immediate household. The major finding was that the neighborhood is an important place for socializing with both family and friends for this population as is the case for working-class white elderly adults.

Wu, F.Y.T. "Mandarin-Speaking Aged Chinese in the Los Angeles Area." The Gerontologist (June 1975): 271-275.

The author examined the adjustment to a new culture and environment of 50 Mandarin-speaking elderly who had immigrated to this country at a relatively old age. The authors focused on this group's adaptation to social and cultural changes, their perceptions of changes in social status, their attitudes toward filial responsibility and intergenerational relations. He concluded that the Mandarin-speaking elderly are the victims of political, social, economic, and cultural changes, including the change in the concept of filial piety. Inability to speak or understand English was seen as the most serious problem. In addition, the author stated that "Language barriers and cultural shock alientated the Chinese elderly from the mainstream of American society and excluded them from receiving services."

Suggested Training Activities

Selected articles are summarized and can serve as a basis for discussion. The selection should continue to be updated and can be adjusted to meet regional needs.

Time should be given to explain research techniques and terminology that may be unfamiliar to the participants, e.g., sample size, research instruments, and statistical tests.

Training participants can be asked to design their own research questions regarding the role of ethnicity and cultural diversity in problem identification, causation, treatment planning, etc.

Human Behavior Models

An ethnic group is "a dynamic system constantly changing, adjusting, and adapting to the wider environment of which it forms a part" (Holzberg, 1982, p. 254). This unit, therefore, provides human behavior concepts related to the aged client within that context. In addition, human behavior content for cross-cultural human service delivery needs to provide a means of accounting for "the interaction of structural and psychological relations within a specific population" (Kobata, Lockery, & Moriwaki, 1980, p. 455). This section suggests three theoretical frameworks for examining the dynamics of cross-cultural relationships which can enable workshop participants to differentially assess minority aging individuals and their families: the dual perspective, systems theory, and the ethnosystem approach.

A number of explanatory models to account for and understand the dynamics of ethnicity have been devised. Green (1982) has placed them into two broad categories: (1) those explanations that treat ethnicity as a categorical phenomenon, and (2) those that approach ethnicity from a transactional perspective. Categorical explanations of ethnicity explain cultural differences according to the degree to which individuals or groups manifest specific, distinctive traits; e.g., because individuals may dress, talk, eat or act in a certain way, they are categorized as culturally different.

Transactional definitions of ethnicity, on the other hand, examine the way in which people who are communicating (across social boundaries) maintain their sense of cultural distinctiveness. Such definitions are concerned with the way in which "distinctiveness is defended, asserted, preserved or abandoned" and/or the degree to which claims of ethnic uniqueness are given up "in favor of the generalized cultural characteristics thought to be typical or desirable for the larger society" (Greene, 1982, pp. 10-12). In the transactional approach to ethnicity, the one to be presented here, the relations between the larger society and persons who identify themselves with an ethnic group are of central interest.

> By virtue of minority group membership, minority elderly share common characteristics and life experiences with others of their reference group (i.e., history of slavery, experience of segregation, minority status, etc.). However, each individual's experience, response, and coping strategies differ, and may have differed at particular stages of their lives. Thus it is important for students to be aware of the macro influences on aging minorities, reference group responses, and individual responses. These experiences and responses influence problem definitions, behaviors that are considered adaptive, and the configuration of significant others in the client system. The range of definitions of family, and community may vary from one culture to another, as will values, roles, and relationship patterns (Soniat, 1982, p. 10).

One framework that can be adapted to assess the minority and/or ethnic group client in relation to the broader society is the dual perspective. The dual perspective is the conscious and systematic process of perceiving, understanding, and comparing simultaneously the values, attitudes and behavior of the larger societal system with those of the (minority) client's immediate family and community system (Miller, 1980; Norton, 1978).

The dual perspective concept addresses the fact that ethnic and minority group members must deal with both the larger or more dominant system and the more immediate system of family and close community. The larger or "sustaining system" controls the individual's instrumental needs, goods, and services, economic resources and political power. The immediate system or "nurturing environment" provides a person's basic sense of identity (Chestang, 1976). The practitioner who understands the dual perspective is better able to recognize when these two systems are in conflict, and is then able to select methods of problem resolution (Bush et al., 1983). Not only does the dual perspective provide a framework for the acquisition of micro and macro knowledge about the minority aged individual, it also fosters an accepting and nonjudgmental attitude towards cultural differences and the development of communication skills.

Social systems theory is another framework that is widely used for analyzing the person-in-the-situation. It is an analytical model to examine and explain how a group of persons interact and influence each other's behavior (Anderson & Carter, 1983). Because of its interactional perspective, it is well-suited for appraising the transactions between and among ethnic and minority groups.

Systems theory, as described by Berger and Federico (1982), is an integrating tool for incorporating information from multiple sources into a coherent whole. For this reason, it is a useful framework for assessing the minority and/or ethnic group client from a biopsychosocial perspective, and also allows for the identification and consideration of data on the family, community, and larger political and economic systems that impact upon the client's problem and treatment plan.

In an effort to define a model of analysis that would permit a more multi-causal, holistic explanation of black-white relationships in the United States, Solomon (1976) developed the concept of the ethnosystem. While it was originally seen as a means of understanding the black experience in America, it offers a framework for considering how any particular ethnic or minority group interacts with "society at large" (see Appendix A).

An ethnosystem is defined as:

> A system comprising smaller groups or collectivities of individuals whose ethnicity serves to define them and their relationship to the whole--either by self-determination or by determination of others in the system. More specifically then, an ethnosystem is defined as (1) a collectivity of

> interdependent ethnic groups, (2) each in turn defined by some unique history and/or cultural ties, and (3) bound together by a single political system (Solomon, 1976, p. 45).

The perspective of an ethnosystem suggests that all (ethnic) communities in North America are open systems whose viability depends on a continuous interchange with successively more encompassing systems. This conceptualization of the United States as an ethnosystem, or collectivity of ethnic groups, makes it possible to study the variations in cultural patterns and social organization, language and modes of communication, the degree of control over material resources and political power. This theoretical perspective offers an important resource for understanding and working with the minority/ethnic aged who often must face the loss of status and power associated with age, coupled with discrimination associated with their minority group status.

Sample Discussion Questions and Issues

The following systems properties should be addressed in this section.

1. What constitutes a system?

2. How are system boundaries established?

3. What distinguishes a relatively open from a relatively closed system?

4. How do transactions take place within the system and between the system and the environment?

5. How are such transactions related to communication?

6. How does a system's organization relate to its capacity to fulfill its goals (and use social services)?

7. How is a system's organization related to its ability to adapt, effect change, and maintain itself?

The aim of such instruction is to prepare participants to be more open to how minority and ethnic families are organized, and how they interface with the broader community.

Participants should be encouraged to provide examples of the various system properties from their own practice experience with minority elderly.

The Helping Process from a Cross-Cultural Perspective

This section presents methods for the helping process from a cross-cultural perspective which, by definition, involves interacting with clients who are ethnically distinct and serving communities that are culturally unfamiliar. Models of cross-cultural practice are introduced, and information is presented on those minority group members whom participants are likely to serve in their geographic area (see Appendix B).

Ethnicity becomes most apparent when individuals meet others who are culturally different from themselves. In fact, it is the interaction across group boundaries which is ethnicity's defining characteristic. Because of the importance of interaction across group boundaries in defining ethnicity, "the persons who mediate boundaries are critical social actors in the communication of information and the regulation of resources as they affect those groups" (Green, 1982, p. 13). The human service worker is, of course, such an actor.

The characteristics of human service practice across cultural boundaries--interacting with clients who are ethnically distinct and serving communities that are culturally unfamiliar--suggest that practitioners must have knowledge about and skill in responding appropriately in relevant interactions. The acquisition of crosscultural knowledge is the basis upon which ethnic-sensitive practice methods reside.

"A performance-level response of cultural awareness represents a depth of comprehension of others that surpasses the usual injunctions about patience, genuineness, and honesty in client-worker relationships" (Green, 1982, p. 52). Working effectively with members of diverse cultures necessitates that practitioners appreciate and utilize their knowledge of that culture to assist with the resolution of a human problem. In essence, this means that the practitioner is able to conduct his/her "professional work in a way that is congruent with the behavior and expectations that members of a distinctive culture recognize as appropriate among themselves (ibid.).

At least four modes of practice intervention with minority groups involve a mediating function. These have been defined as (1) group advocate, (2) counselor, (3) regulator, and (4) broker. The group advocate works to challenge and change unfair practices and inequities in minority-dominant group relationships. The advocate generally questions the manner in which services are delivered, and seeks to make dominant institutions responsive to minority clients. The counselor works with the individual, and seeks to achieve change within a "one-to-one" or small-group relationship. The counselor generally views his/her responsibility to the client not to the community as such, but nonetheless must be culturally sensitive.

A third mode of intervention is the regulator who is, in effect, an extension of the larger society. The regulator aims to change or modify the client's behavior or attitudes with resocialization as the major goal. The fourth method of intervention is to act as intermediary or broker between the individual and society. This approach, which stresses the dual responsibility, aims to evaluate and modify problems within the context of the social and cultural resources of the client's community (Cowger, 1977; Green, 1982; Seabury, 1982).

Suggested Training Activities

Because each minority group represents a unique configuration of history, heritage, value systems, culture and life experiences, there have been a number of questions about how best to develop assessment and treatment methods which will be appropriate for use with diverse ethnic and/or minority groups (Soniat, 1982).

One approach is to provide participants with model(s) for ethnic-sensitive practice (Devore & Schlesinger, 1981; Green, 1982; Solomon, 1976). These can serve as a general guide whenever social workers are in contact with clients who are culturally or racially different from themselves (see Appendix B for summary of the models).

Trainers may also elect to better prepare participants to serve those minority group(s) with whom they are likely to work in their geographic area. This can be accompanied by selecting specific readings, films, etc., to supplement general models.

Still another strategy is to make positive, continuous efforts to assure that cross-cultural information is provided throughout the continuing education curriculum. A combination of these teaching techniques is likely to be most helpful.

The effectiveness of cross-cultural communication, regardless of the model used, is based on an awareness of one's own cultural limitations and an openness to cultural differences. Therefore, it is important to incorporate opportunities for participants to review their own cultural background and consider how that affects their role as a social worker (see Appendix C for Guide for an Ethnic Autobiography).

Using case studies of ethnic groups with which trainees are likely to come in contact in their practice, participants can also be asked to engage in role play to show how each of the four modes of intervention with minority groups can be applied to practice.

Service Needs

This unit focuses on the service needs of ethnic and minority aged and the extent to which they are being met. Discussion includes the role of practitioners in diagnosing problems and devising service plans that are sensitive to the diversity of family cultural patterns. Discussion will also focus on how social service systems can effectively respond to the specific needs of ethnic and minority aged.

Older people are a multi-ethnic and multicultural group; yet despite this heterogeneous population, most programs and services for the elderly are designed to meet the needs of the majority, and lack the flexibility to adequately respond to minority groups.

One of the key issues raised at the 1981 White House conference on Aging was how social service systems and benefit entitlement programs can be implemented to insure responsiveness to the cultural and social differences that characterize the older American population. In an effort to improve services to minority groups, delegates recommended that in the design of programs, special attention be given to the diversity of family and cultural patterns that exist among diverse groups. They also stated that "options should be available so that older persons can exercise their right of choice with respect to decisions affecting their daily lives" (Technical Report, White House Conference, 1981, p. 6). It was cautioned that lack of sensitivity to "the differing values of the service provider and the consumer can result in culturally incompatible services that are inaccessible to the ethnic client" (Federal Council on Aging, 1975).

In a 1984 survey of community mental health centers by the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, the underservice of the minority elderly was found to be an ongoing problem. The report concluded that:

> The special mental health needs of racial and ethnic minority elderly have been sorely neglected by both public and private mental health systems. The community mental health movement of the 1960s and 1970s largely ignored the minority elderly; their service needs were never adequately assessed and prevention and treatment programs were not designed to deal with their unique problems. Consequently, the minority aged continue to be significantly underrepresented in the utilization of mental health services (see Kobata, Lockery, & Moriwake, 1980).

Sample Discussion Questions and Issues

The urgency of this issue cannot be brought home to workshop participants simply by providing factual information. Participants can be asked to define and describe culturally relevant services. Discussion should move from the abstract to a consideration of how participants would assess their own agency's "climate" for service delivery:

- Do the policies of their agency contribute to ethnic-sensitive service delivery?

- Do the policies take into account the informal self-help resources already in existence in the client's community? (Adams & McDonald, 1982; Greene, 1985)

- How can services be modified to meet culturally diverse needs? Would such changes be feasible within the agency? What problems does this raise for the agency and the practitioner?

- Participants may also want to address the question of whether they have a role in policy setting within their own agency structure and, if so, how (Prunty, 1980).

Summary of Practice Implications

An awareness of one's own cultural affiliation and an openness to cultural differences are only the first steps in being able to provide culturally relevant social services. While practitioners may generally accept the idea that there are cultural differences among clients, and that differences are important, they must also be prepared to identify client problems, devise a plan, and offer services within clients' cultural context. Practitioners cannot possibly be conversant with all cultures, or the variations within groups. Therefore, the client is the best source of information about the impact of culture on lifestyles, beliefs, values, problems and the means of their resolution. Each requires a thorough exploration with the client so that the implications for practice will be understood.

Suggested Training Activities

Some of the important ways in which cultures may vary is reflected in the list of questions below, which can serve as a guide for interviewing.

1. What does the client define as the problem?

2. What are the client's help-seeking behaviors?

3. What are the client's health practices?

4. From whom (family, minister, doctor, natural healer) would your client prefer to receive help?

5. What are the client's attitudes toward filial piety and responsibility? What are family roles?

6. How does the client view "old age"? How are the elderly treated in his/her community?

7. What are the client's attitudes toward death and dying? Funeral practices? Other religious rituals?

In order for workshop participants to gain a better understanding of problem-solving within a cross-cultural context, they can be given the opportunity to experience interviewing someone who is culturally different from themselves. This can be accomplished by asking participants to pair off with another workshop member they do not know, with one person acting as the client, the other as the interviewer. The practitioner will interview the client with the purpose of understanding how he/she would go about deciding whether or not to place his/her incontinent, mentally impaired mother in a nursing home. After the "interviews," participants should be asked to report back to the group on their experience and the issues and problems encountered. This role play exercise may also be applied to their practice situations in terms of the questions and issues that emerge in the worker-client interactions.

ANNOTATED BIBLIOGRAPHY

Candlin, S., and Braun, K. "Determinants of Placement After Hospital Discharge: The Role of Ethnicity." Paper presented at the Gerontological Society of America, San Antonio, Texas, November 18, 1984.

This study explored the use of nursing home care for the dependent elderly in Hawaii, and variables related to whether the patient was discharged to nursing home care vs. discharged to his/her home with family. The factors examined included ethnicity (Caucasian, part Hawaiian, Japanese, Filipino, Chinese), gender, age, marital status, living arrangements prior to admission, presence of relatives on the island of Oahu, number of anatomical systems involved in pathological changes, type of anatomical system involved, activities of daily living score, and number of days spent in acute care. Gender, ethnicity and family on Oahu did not prove to be significantly related to placement. However, marital status and living arrangements prior to hospitalization did prove significant. Patients were more likely to go home to a spouse or family they lived with prior to admission.

Chunn, J.C., Dunston, P., and Ross-Sheriff, F., eds. Mental Health and People of Color. Washington, DC: Howard University Press, 1983.

This text represents the collective effort of sixty-four contributors hoping to bring greater recognition to the unmet mental health needs of people of color as reflected in training and service. It is an outgrowth of a grant from the National Institute of Mental Health to address the mental health needs of Blacks, Asian and Pacific Americans, American Indians, Alaska Natives, and Hispanics. It is divided into four sections by professional discipline including psychology, social work, psychiatry, and psychiatric nursing. While the aging are not dealt with specifically, the basic issues addressed such as the behaviors of an ethnosystem, systems theory, and the goal of empowerment, will be invaluable to the geriatric social worker.

Devore, W., and Schlesinger, E. Ethnic-Sensitive Social Work Practice. St. Louis, MO: C.V. Mosby Co., 1981.

This book is about ethnicity, social class, and social work practice. The authors' purpose was to "delineate how understanding of class and ethnic factors could contribute to assessment and intervention process." As a result of this interest, they developed a model for ethnic-sensitive practice which builds on social work values, the conception of ethnic reality and its relationship to the life cycle and the view of social work as a problem-solving endeavor. The elderly are discussed as part of the life-cycle approach to practice.

Faulkner, A.O., Heisel, M.A., and Simms, P. "Life Strengths and Life Stresses: Exploration in the Measurement of the Mental Health of the Black Aged." *American Journal of Orthopsychiatry* 45, *1* (January 1975): 102-110.

This article describes an attempt to understand the self-concept, social characteristics, personal strengths, and frailties of a group of older black men and women in order to tailor mental health and social work services to their needs. "Difficulties inherent in obtaining such information were minimized by a methodology that integrated the research and service aspects of the project." Results of the pilot study, funded by NIMH, and service implications are discussed.

Gelfand, D. "Ethnicity, Aging, and Mental Health." *International Journal of Aging and Human Development, 1979-80*, 10, *3* (1979-80): 289-297.

This article explores the relationship between ethnicity and mental health of the elderly. It includes a discussion of the concept of ethnicity, ethnicity and immigration, aging and family interaction, aging and ethnicity, communities and mental health and implications for research and training.

Green, J. *Cultural Awareness in the Human Services*. Englewood Cliffs, NJ: Prentice-Hall, 1982.

This book makes a major contribution to the area of cross-cultural social work. It provides a basic introduction to the major issues related to the cultural aspects of social service delivery, a cross-cultural practice model, specific information on the needs of minority clients and minority communities, and an appendix of cross-cultural learning activities. While it does not specifically deal with the aged, the text offers a model for practice most appropriate to this client population.

Greene, R. "Overcoming Learning Resistance to Ethnic/Minority Content: Discovering a Cross-Cultural Perspective in a White-Middle-Class Community." Paper presented at the Council on Social Work Education Annual Program Meeting, Washington, DC, February 1985. To appear in *Arete* Fall 1985 or Spring 1986.

This paper presents four learning assignments for students in an elective course entitled Social Work with Different Cultural Groups. The major goal of the course is to sensitize "white middle-class" students to issues of ethnicity, social class, and racism by fostering self-awareness and encouraging cross-cultural experiences. The learning assignments include an ethnic autobiography, a client study, a media analysis and discussion and a role play. A Likert attitude scale, devised by the author and in its developmental stage, is also presented.

Kobata, F.S., Lockery, S.A., and Moriwaki, S.Y. "Minority Issues in Mental Health and Aging." In J.E. Birren and R.B. Sloane, eds., Handbook of Mental Health and Aging. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980, pp. 448-467.

This chapter in an excellent and comprehensive handbook raises "issues which may stimulate further exploration of the complex world of the minority elderly and the resultant implications for their mental health." The authors point out that many generalizations are made from the scant existing sources available on the subject of minority issues in mental health and aging. They caution the reader about applying these generalizations in working with different ethnic elderly groups and suggest that one be aware of intra- and inter-group diversity and variation.

Lowry, C. "Great Grandma's Name Wasn't Scarlet: Using Family Histories to Teach Ethnic Content in Changing Roles of Women." Paper presented at the Annual Meeting of the Council on Social Work Education, Boston, Massachusetts, 1979.

This paper outlines an assignment for an elective course on "The Changing Roles of Women" in which students were asked to trace the history of the women in their family. The family histories strongly reflected the rural, southern heritage of the class members and showed that black students and white students shared many values based on economic struggle and religious beliefs. This is not to say that students did not also learn that being black in the South posed special problems. The professor concluded that the family history technique could be an effective way to examine other critical aspects of human behavior such as child rearing practices or the care of the elderly.

McCaslin, R., and Calvert, W.R. "Social Indicators in Black and White Ethnic Considerations in Delivery of Service to the Elderly." Journal of Gerontology 30, 1 (1975): 60-66.

This study was conducted at the Houston Areawide Model Project for the Elderly and involved a random sample of Black, Hispanic, and "Anglo" elderly who contacted the Central Intake Referral and Information Service. The subjects were interviewed using DHEW's Social Indicators for the Aged. (Items considered: housing, neighborhood, social relations, activities, health, economic well-being, independence, and life satisfaction.) An analysis of those data by ethnic group revealed that Anglo elderly spoke more favorably than any other ethnic group in every category measured. Income, health, and life satisfaction showed the strongest differences by ethnic group.

Prisuta, R.H. "Gender/Ethnicity Differences in Self-Reported Social Indicators Among the Elderly." Washington, DC: American Association of Retired Persons, 1984.

This paper excerpts findings from annual surveys conducted by the AARP on issues of health care, employment, income, housing, social status, policy, and quality of life. Minority and female responses were compared to those of the general older population. The results highlight the variability of the older population. They show that gender and ethnicity are important variables in differences in standard of living/quality of life indicators. Minority elderly indicated they experienced lower incomes, lower health status, poorer housing, and less choice in retirement and employment than the general population.

Sauer, N. "Morale of the Urban Aged: A Regression Analysis by Race." Journal of Gerontology 32, 5 (1977): 600-608.

This research examined the degree to which previous factors shown to be related to morale (derived from a body of research based primarily on white subjects) were isomorphic for aged whites and aged blacks. The data were collected from a large sample of low-income aged blacks (N=722) and whites (N=214) in Philadelphia. The results of a regression analysis indicated that for blacks the two significant predictors of morale were health and participation in solitary activities. For whites, in addition to health and solitary activities, interaction with family and gender were also found to be significant. It was concluded that for these data the predictors are not isomorphic between races.

Sherman, G.A., ed. Curriculum Guidelines in Minority Aging. Washington, DC: National Center on Black Aged, Inc., 1980.

This curriculum guide, which was developed under an Administration on Aging grant, provides an expanded outline and resource guide for teaching courses on the minority aged. There are specific outlines and content on the Black, Hispanic, Pacific/Asian, Native American aged. It presents content on research, social and legislative policy, history and culture, demographic charactersitics, intergenerational relationships, language, etc. It is a rich resource as it addresses each minority from its unique perspective with ample reference to diversity within each group. The section on Native American Indians is particularly valuable in its excellent coverage of the legal and political decisions affecting this group.

Starrett, R.A., Mindel, C., and Wright, R. "The Utilization of Community Mental Health Services by the Hispanic Elderly." Paper presented at the Gerontological Society of America, San Antonio, Texas, November 1984.

Empirical studies pertaining to the utilization of community-based mental health services by the Hispanic elderly are absent from the gerontological literature. The purpose of this study was not only to identify and describe correlates of social service use but also to attempt to develop and test a conceptual framework about "complex behavioral processes" and causes for underutilization. The study pays particular attention to the role of need, family and community resources, and background characteristics in accounting for differences in mental health services use.

Stiles, E., Donner, S., Giovannone, J., Lochte, E., and Reetz, R. "Hear It Like It Is." In H. Rubenstein and M.H. Bloch, eds., *Things that Matter: Influences on Helping Relationships*. New York: Macmillan Publishing Co., Inc., 1982.

This article discusses the need for open communication about race differences early in the casework relationship, and suggests that for communication to be open the discussion of race has to become an integral part of the casework treatment. The development of a constructive relationship rests on this mutual respect, and the legitimacy of both the worker's and the client's life experiences.

Sue, D.W. and Sue, D. "Barriers to Effective Cross-Cultural Counseling." *Journal of Counseling Psychology* 24, *5* (1977): 420-429.

This article notes that mental health professionals can experience racial and ethnic factors as impediments to counseling, and that misunderstandings may arise from cultural variations in verbal and nonverbal communication. This can lead to alienation and/or an inability to develop trust and rapport. The authors discuss three variables that they believe interact to hinder counseling with "third-world groups: language barriers, class-bound values, and culture-bound values." They offer suggestions for overcoming these difficulties.

Thomas, P. "Understanding Minority Communities from a Cultural Perspective." Washington, DC: National Institute of Mental Health, The Staff College, October 1980.

The paper begins with an introduction and a definition of needs assessment, a brief description of several needs assessment approaches, the utilization of the participant observer method in conducting needs assessments, and concludes with a presentation of suggested methods and procedures to be used when conducting needs assessments in minority communities. The author suggests that the use of appropriate needs assessment instruments is the key to providing relevant services to underserved, unserved and culturally diverse groups.

Usui, W.M. "Homogeneity of Friendship Networks of Elderly Blacks and Whites." *Journal of Gerontology* 39, *3* (1984): 350-356.

This paper examines the friendship network of elderly adults in terms of three ascribed statuses (race, sex, and age) and two achieved statuses (marital status and education) in order to assess (a) the relative levels of network homogeneity on these parameters and (b) the influence of other variables on homogeneity of friendship. Race and sex were found to be the most salient parameters of friendship (how close respondents felt to their friends).

Usui, W., Keil, T., and Phillips, D. "Determinants of Life Satisfaction: A Note on a Race-Interaction Hypothesis." Journal of Gerontology 38, 1 (1983): 107-110.

This article examines the issue of race differences in life satisfaction of blacks and whites. While a "race interaction" hypothesis would suggest that factors important to the life satisfaction of whites may not be important to the life satisfaction of blacks, this was not the case according to this study. It was shown that most factors influencing life satisfaction of elderly people have similar effects among blacks and whites. Although greater numbers of impairments lead to lower life satisfaction for both races, these findings suggest that the negative effect is considerably stronger among black than among white respondents.

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AUDIOVISUAL RESOURCES

Old, Black and Alive 25 min., 1984
National Black Caucus on the Aged

Through a series of interviews and visits with elderly Black persons in Georgia, the dignity, strength and individuality of each person is dramatically underscored. Exceptionally well done, this film offers an excellent opportunity to view the concerns and perspectives of several Black elderly persons.

Annie and the Old One 15 min., 1975
BFA Education Media, Santa Monica, CA

This technically excellent film depicts a Navajo family as they prepare for the grandmother's (the Old One) "return to Mother Earth." Annie, who is very close to her grandmother, cannot accept this and eventually must seek guidance from the Old One to understand Navajo beliefs.

So Far From Home: Elderly Hispanics in the U.S.
30 min., 1984
National Public Radio (140-82-09-15)
Washington, DC

Experts explore the problems, concerns and fears particular to America's Hispanic elderly. The film focuses on the Hispanic family and community and how aged individuals are coping in their "adopted land."

APPENDIX A

SOCIETY

ANGLO COMMUNITY

VALUES

BLACK COMMUNITY

KNOWLEDGE

EXTENDED
BLACK
FAMILY

BLACK
CHILD

BLACK
PARENTS

BLACK COMMUNITY

ANGLO COMMUNITY

SOCIETY

SKILLS

FIGURE 1
A Framework for Understanding the Behaviors of an Ethnosystem

J.A. Bush, D.G. Norton, C.L. Sanders, and B.B. Solomon, "An Integrative Approach for the Inclusion of Content on Blacks in Social Work Education," in J.C. Chunn II, P.J. Dunston, and F. Ross-Sheriff, eds., _Mental Health and People of Color_ (Washington, DC: Howard University Press, 1983), pp. 97-121.

APPENDIX B

Three Models for Cross-Cultural Social Work

I. Ethnic-Sensitive Practice from W. Devore and E.G. Schlesinger, Ethnic Sensitive Social Work Practice

"Social work practice needs to be grounded in understanding of the diverse group memberships people hold. Particular attention must be paid to ethnicity and social class, and how these contribute to individual and group identity, disposition to basic life tasks, coping styles and the constellation of problems likely to be encountered. These together with individual history, and genetic and physiological disposition, contribute to the development of personality structure and group life."

The basic assumptions of ethnic-sensitive practice are:

1. Individual and collective history have bearing on problem generation and solution;

2. The present is most important;

3. Nonconscious phenomena affect individual functioning;

4. Ethnicity is a source of cohesion, identity and strength as well as a source of strain, discordance and strife.

In addition to these assumptions, ethnic-sensitive practice is based upon a particular set of principles which include:

1. Simultaneous attention must be given to individual and systematic concerns as they emerge out of client need and professional assessment;

2. Practice skills must be adapted to respond to the particular needs and dispositions of various ethnic and class groups;

3. The "Route to the Social Worker" affects problem definition and intervention.

II. Ethnic Competent Social Work from W. Green, Cultural Awareness in the Human Services

"To be ethnically competent means to be able to conduct one's professional work in a way that is congruent with the behavior and expectations that members of a distinctive culture recognize as appropriate among themselves."

Ethnic competence includes:

Steps in Cross-Cultural Learning:

1. Background Preparation - entering an unfamiliar community;
2. Cultural Guides - key respondents;
3. Participant Observations.

III. Empowerment from B. Solomon, Black Empowerment: Social Work in Oppressed Communities

"Empowerment refers to a process whereby persons who belong to a stigmatized social category throughout their lives can be assisted to develop and increase skills in the exercise of interpersonal influence and the performance of valued social roles."

The basic tenets of empowerment are:

1. Everyone is powerless to some degree due to limitations in his/her self-determination and sense of dependency.
2. Minority group members, who have been subjected to negative valuations from the larger society, are collectively stigmatized, and therefore powerlessness in the group is pervasive.
3. The experience of these negative valuations is not uniform throughout the group, and there may be a multiplicity of individual responses.
4. Assessment of the effects of power blocks on the etiology of problems and capacity for solving them require knowledge of the nature and dynamics of growing up as a member of a particular minority group.
5. The social work challenge is to make bureaucracies work for powerless people instead of against them. Activities are aimed at obtaining resources and using them to achieve personal and/or minority community goals.
6. General models of practice, including casework, social group work, and community organization, are employed with the social worker implementing their function in such a way as to address the uniqueness of the individual and the issue of power by:
    a. helping the client perceive himself as causal agent in achieving problem resolution;
    b. helping the client perceive the practitioner as having knowledge and skills which he (the client) can use;

c. helping the client to perceive the practitioner as peer-collaborator in the problem-solving; and

d. helping the client to perceive the "power structure" as open to influence.

APPENDIX C

Guide for an Ethnic Autobiography*

These questions are meant as a guide for your autobiography. You may feel that some of this information is personal in nature. Be assured that it will be treated as such. You will need to make a choice regarding what you are comfortable including and what you want to think about in private.

These questions are intended to help you give some thought to your personal identity in terms of "race," class and ethnicity (whether you view yourself as belonging to a "minority" culture or the "majority" or "core" culture).

1. Describe your family of origin including information on: (a) composition/members (parents, siblings; birth order, etc.); (b) ethnic identity; (c) socio-cultural background (class); and (d) neighborhood. Do you consider yourself to be upper, middle or lower class? What meaning do you attach to this label?

2. What is your first recollection about your ethnicity, "race," or class? (a) How did you come to realize you are white, black, Italian American, middle class? (b) How did you come to identify with any group and to learn that there are "others"? Who were (are) defined as "outsiders" and "insiders" by your family or group? Do you recall "journeying out of your own world" entering the mainstream?

3. What went into the formation of your ideas in regard to your own physical appearance and what did you consider to be attractive that might be related to ethnicity, class or "race"? For example, do you admire certain color hair, size of nose, shape of lips?

4. Who were your playmates and friends when growing up? Today? Who lived in your neighborhood? Who was a "desirable" friend to bring home? How did you select your dates, roommates, mates? Sexual taboos? Does this relate to ethnicity, class, "race"?

5. Can you relate any of your tastes in food, music, art, clothes, furnishings, activities and games to ethnicity, "race," and class? What about modes of expression, i.e., language accent, proverbs?

6. Can you relate your educational aspirations, choice or use of special schools and/or choice of profession to the aspirations of "your group"? Optimism vs. pessimism about these aspirations? "Aggressiveness" in pursuing?

7. What have you learned about how children "should" behave and how sex roles are defined that could be related to your ethnic, class or "racial" identity? Should women work? Who is the head of the family?

8. How do you perceive the relative power position(s) of particular individuals and families as related to their social class, "race," and/or ethnicity? How do these individuals and/or groups vary in political power and decision-making authority? Attitudes toward government and the role of the state? How would you relate this to the way social services are delivered and their accessibility?

9. How would you want to define your role as social worker considering your thoughtful answers to the above questions?

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*R. Greene, "Overcoming Learning Resistance to Ethnic/Minority Content: Discovering a Cross-Cultural Perspective in a White Middle-Class Community." Paper presented at the Council on Social Work Education Annual Program Meeting, Washington, DC, 1985.

GROUP PROCESSES IN WORK WITH THE AGED

This module focuses on the value of group services with older adults as planned, purposeful activities grounded in a theoretical base. Information on five specific types of groups suitable for treatment of the older person and/or his/her family is presented: (1) reality orientation groups; (2) reminiscing groups; (3) group psychotherapy; (4) groups for caregivers of the elderly and 5) task-centered and problem-solving groups. The effectiveness of group work interventions is also explored.

The material covered in this unit first addresses the basic principles of social group work (Galvin, 1981; Lang, 1981; Lowy, 1979; Roberts & Northern, 1976) followed by a presentation of specific group services available for use with the older adult; toward the goal of preparing participants to carry out planned, purposive and therapeutic group activities.

The purposes of this module are to:

- Provide information on social group work as a method of intervention;
- Discuss several group treatment approaches, their rationale and techniques;
- Describe the skills needed for group leadership as related to the theory of the group;
- Analyze why certain groups are suited for particular clients;
- Detail the expected outcome(s) of each group treatment.

The learning outcomes for particpants are to:

- Increase knowledge of the types of group treatments available and the benefits of each;
- Identify the role and functions of the group leader;
- Differentiate the processes and theoretical bases of each of the five group approaches;
- Using case material, demonstrate accuracy in referring aged clients to different types of groups on the basis of their primary problems and diagnosis;
- Increase knowledge of the expected outcomes of five different group treatment approaches.

Definitions

A Group is more than simply an aggregate of individuals, it has a unique wholeness of its own. . . . The human group is to be viewed as a system distinguishable from its environment, having the properties and functions of a system, and providing the connectiveness between its component and its environment (Anderson & Carter, 1978, pp. 84-85).

A group is a stable aggregate of individuals with varying amounts of intimacy, size, composition, tasks, degree of formalization, and the self-consciousness of participants. It is a collection of persons who are capable of consistent, coordinated action which is directed toward some common objective (Shimbutani, 1961).

Social group work is a social work method "which places emphasis on group development (maximizing group processes), so that the group may become the instrument in which and through which participating individuals may benefit, their interpersonal relationships may improve, and/or the participants may collaborate in improving their social conditions" (Hartford, 1980, p.816).

Group therapy is the use of group methods and activities to encourage personal activity, sociability and social integration of the indvidual member (Goldfarb, 1971, p. 623).

Group therapy is a form of treatment where there are defined individual problems, personal, mental, emotional, physical or relationship in nature, and where the focus is on the rehabilitation of each participant (Hartford, 1980, p. 817).

Group work practice, and the theory that supports it constantly evolves in response to the experiences of social workers working with groups, the forces affecting the profession of social work, increases in knowledge about human behavior, and social and ideological conditions of the society in which we practice (Garvin, 1979, p. 55).

Characteristics of Group Treatment

Over the last thirty-five years, there has been a growing interest in the use of group services in many different settings serving the elderly. A number of group approaches have been adopted, ranging from recreational and vocational to physiotherapeutic (Goldfarb, 1971).

While all the approaches to working with the elderly in groups are based on psychosocial theory and use professionally validated techniques, each method has its own historical roots and unique methods. At the same time, it is possible to define the more general characteristics of the process.

Social group work is a method that emphasizes group development; the group provides the vehicle by which individuals may improve their interpersonal relationships and/or their environmental or social conditions. The focus is on group process, collective support and interaction as a means of enabling individual members to grow and develop and/or to achieve a task.

Lang (1981) characterizes the social work group as a unique social form that operates as a mutual aid system that promotes autonomy and benefits the individual members through the effective action of the whole group. She also suggests that the social work group is defined by professional and group norms which reinforce acceptance, respect, open communication, tolerance of differences, and democratic group functioning (see appendix A).

Galvin (1981) rejects the idea that any and all ideas about work with groups are equally valid for use by practitioners, and suggests that consideration be given to whether particular groups are a legitimate part of the "professional heritage of social group work." He offers the following guidelines:

(1) Any approach to the use of groups must be consistent with our belief in self-determination and respect for individuals;

(2) Social group work practice seeks to enhance the social functioning of the members through helping persons to alter either themselves or their social environments or both;

(3) Social group work services must be useful to those persons who represent important professional commitments namely, persons who are oppressed by virtue of their economic, physical, social, educational status or other circumstances; and

(4) Social group work interventions must be susceptible to information gathering regarding their effects (see section on research) (Galvin, 1981, pp. 59-60).

Sample Discussion Questions and Issues

Galvin's statements about suitable circumstances of and conditions for group work practice should be explored in relation to practice situations.

Training participants can be asked to share any group work experience they have had in providing services to older adults. Do the agencies in which they work offer group treatment? If so, what kinds of groups, who leads them, etc.

What are some of the goals and purposes of group work in their agencies?

Case Example:

A group of older adults meet once a week in the agency conference room. Although referrals to the group are frequently made by the agency's workers, no professional staff member conducts the group. The group gets together "just to talk." Why is this not an example of social group work according to Galvin's definition?

What might be some of the advantages and disadvantages of this type of group?

Group Intervention Approaches

This section describes five distinct group approaches particularly suitable for working with the older adult and his/her family. Each group method is discussed within the context of human behavior theories.

Human Behavior and Methods

The selection of group approach for working with the elderly and their families should be based in human behavior theory. As an arena of social interaction, groups have the potential for meeting a number of human needs that cannot always be met through individual therapy. These include the need to belong and be accepted, the need to be validated through feedback processes, the need to share common experiences with others, and the opportunity to work with others on common tasks (Anderson & Carter, 1984). Other intrinsic properties of group interaction include the opportunity to share, to explore the universality of human problems, and to work towards making decisions.

Group participation may also be instrumental in helping older individuals cope with the changes associated with the aging process. This ability to cope successfully is, of course, basic to meeting all other needs. Expressive needs, or those associated with fulfilling oneself by engaging in activities for their own sake, can also be met through group participation. In the younger years, expressive needs are often difficult to meet due to the demands of work and family and the later years may offer new opportunity (Lowy, 1983).

Groups also provide an opportunity for older adults to make a contribution to others and exercise what Butler (1982) has referred to as the "elder function." Intergenerational groups are particularly useful in this regard. As people grow older, their influence may diminish greatly and they may often be relegated to an inferior status. Participation in group associations, such as the Gray Panthers or senior center boards, may allow older persons to continue to enjoy a sense of mastery and autonomy as well as exert some measure of control (Lowy, 1983).

The success of any particular form of social group work rests, in large measure, upon the preparation of a practitioner well-grounded in its theoretical framework and technique. That framework and the purpose of the group suggest the treatment modality, and the role of the practitioner in facilitating the achievement of treatment goals.

Reminiscing Groups

Reminiscing plays an important role in maintaining psychological health throughout the life cycle. This is seen as particularly true in old age when introspection becomes one key to resolving the crisis of integrity vs. despair: a process involved in the positive acceptance of one's life and impending death (Erikson, 1950).

In a hallmark article, Butler (1963), proposed that life review was a "progressive return to consciousness of past experiences in an attempt to resolve them," and was a naturally occurring process having adaptive value. Later writings confirm that reminiscing can help older persons clarify family roles, cope with stress and grief, experience pleasant images, maintain a sense of adequacy, and give renewed opportunity for ventilation about loss (Greene, 1982; Ingersoll & Goodman, 1980).

Ebersole (1978) maintains that "the major reason to encourage reminiscing among a group of aged people is to produce or enhance a cohort effect" (p. 237). She points out that in addition to the multiple interaction possibilities, by sharing reminiscences, individuals can slowly begin to identify their accomplishments, tribulations and shared viewpoints.

Butler suggests that a majority of elderly persons can benefit from life review, and that for many a "substantial reorganization of personality does occur" (1963, p. 490). While reviewing one's life has several potential benefits, there are persons for whom this treatment modality is counterindicated. One such group is composed of those who seem especially prone to anxiety, despair, depression or place great emphasis on the future. Another group of individuals that appear to have a more negative outcome to life review is those who have "consciously exercised the human capacity to injure others" (p. 491). Therefore, as with all group treatment, the suitability of members for life-review groups, should be assessed on an individual basis.

Reminiscing groups can be short-term (ten weeks or less) or long-term (more than a year). The group should be kept small (5 or 6, but no more than 10). Each member should be approached individually about the opportunity to participate in the group. The group should meet at consistent intervals at the same time. Content can be structured at times with visual devices such as The Time Line (see appendix B) (Ingersoll & Goodman, 1980; Jewish Family and Children's Service of Baltimore, 1978). The group process, of course, includes beginning, working and termination phases, each of which should be well planned.

The role of the practitioner is to encourage reminiscing in a manner that facilitates adaptation by clients (life-review therapy). The accomplishment of this task, which involves assessment and diagnostic skills, can enable group members to work through past conflicts and deal with stress.

Group Psychotherapy

Group psychotherapy refers to all regularly scheduled meetings of clients with a trained leader for the purpose of gaining personal insight. The goal is to express, elicit, accept and work through various aspects of the clients' functioning and develop heathier and more satisfying potentials. Group therapy, which can be conducted by psychiatrists, nurses, psychologists or social workers, places primary importance on the relationship between the therapist and the group and upon the interaction among group members. The theoretical background adapted by the practitioner suggests the rationale for treatment and defines the nature of that relationship and the goals of the group.

Among the most widely used approaches which may be presented are those based upon Freudian psychodynamics and social systems theory. Group psychotherapy leaders with a Freudian orientation help group members to recall and reconstruct events and emotions from their past that may have been painful or unresolved. Efforts focus on assisting clients to gain insight in turn leading to self-acceptance and better social functioning (Hartford, 1980). The individual's transference with the other members of the group and the therapist, and the interpretations given are the key to treatment.

Group leaders with a systems orientation to group psychotherapy see "the group as an entity," and focus on its process and structure. Their role is to assist participants to understand the group culture, norms, and values. The interpretive role of the practitioner is central to understanding the group structure, improving its stability, and increasing its ability to achieve a common goal or task (Anderson & Carter, 1984).

The leader should determine before the group begins what role he/she will play. There is some debate about appropriate nature of that role. Goldfarb (1971), whose views have been controversial, suggests that the leader can be passive and function as listener and target for the ventilation of clients' feelings, or can be active and assume the role of teacher, facilitator, comforter and moderator. He contends, however, that adaptive capacities can best be tapped by the worker assuming a powerful leadership position (see Goldfarb, 1977; Goldfarb & Sheps, 1977 for a discussion of the aged patient and fostering dependency relationships).

Group psychotherapy is a difficult therapeutic technique to employ with individuals who may not be accustomed to expressing personal problems. Therefore, it is not uncommon for group leaders to experience resistance and for members to drop out. Clients who are introspective and more psychodynamically oriented make the best candidates for this form of treatment. Careful preplanning about the purposes, goals, composition, and leadership of the group may help overcome these difficulties. Culture differences (as discussed in Module 7) should also be taken into consideration.

Reality Orientation Groups

Reality orientation groups are for the confused, disoriented elderly person, and are most often run in nursing homes and other institutional settings However, reality orientation programs can be modified to fit a variety of settings such as day care and multiservice centers. Reality orientation is concerned with the maintenance and/or relearning of current information such as time, place, names of others, and current events. Verbal repetition, the use of visual aids such as weather boards, and stimulation of the senses are the main methods of conveying this information (Wilson & Moffat, 1984).

There are several benefits to working with mentally impaired elderly in a group. According to Wilson and Moffat (1984), many such people believe they are losing their sanity, and this fear may be somewhat alleviated by observing that there are others with similar difficulties. By participating in a well-programmed group, they may observe others, their successes and failures, and also experience their own accomplishments. This is particularly helpful for people who have become increasingly accustomed to not being able to satisfactorily complete tasks.

The confused or mentally impaired elderly person can receive reality orientation in group classroom sessions and/or in the milieu on a twenty-four hour basis. Such programming is based upon accurate and appropriate needs assessment and group assignment. Classroom sessions should be planned to include materials that reflect the needs of the group membership: basic group for the most disoriented and withdrawn who require basic information on time, place, and names of participants; a standard group for the moderately disoriented who need discussion and activities to promote interaction; and an advanced group for those who are mildly disoriented and need more responsibility for determining group activities.

Twenty-four hour reality orientation programs involve reorienting the patient by all residential staff, including orderlies and dieticians. This format can have dramatic effects when coupled with classroom sessions (Taulbee, 1979). In such an ideal program, the role of the practitioner is to engage the staff in establishing and carrying out the 24-hour activity. The practitioner needs to conceive of the nursing home as a system where he/she can help to create a therapeutic atmosphere, including routines, procedures, and policies.

While non-professionals can learn many of the techniques used in conducting a reality orientation group (see Wilson & Moffat, 1984 for a session-by-session agenda), there are some significant advantages to having a trained practitioner as group leader: assessment and appropriate selection of group members; program orientated to members' cognitive levels; and timely evaluation of the progress of group members are some of the major factors that distinguish a professionally conducted group.

Caregivers Groups

Conducting groups with relatives of dependent older adults requires a thorough knowledge of family dynamics and the concepts related to caregiving (see Module 3). It is well-documented that families provide 80 to 90 percent of medically related and personal care. Research on the effects of such caregiving has dramatically increased. As a result, there is a growing body of literature about the difficulties and strains experienced by the adult children of dependent elderly (Brody, 1985); Cantor, 1983).

> . . . study after study has identified the most pervasive and most severe consequences [of caregiving] as being in the realm of emotional strains. A long litany of mental health symptoms such as depression, anxiety, frustration, helplessness, sleeplessness, lowered morale, and emotional exhaustion are related to restrictions on time and freedom, isolation, conflict from the competing demands of various responsibilities, difficultues in setting priorities, and interference with life style and social and recreational activities (Brody, 1985), p. 22).

Recently, in response to these problems, there have been a growing number of groups offered for the families of frail and/or impaired elderly relatives (Aronson, Levin & Lepkowitz, 1984; Cohen, 1983). The goals of these groups are to provide support, enhance understanding of the older relative's problems and behaviors, suggest plans and services that can be made for changes in the older adult, provide insight into the feelings of both the older person and the caregiving relative, and improve coping strategies (Hartford & Parsons, 1983).

Some common themes in groups for caregivers include: (1) relocating a person who becomes too frail or dependent to remain in the original residence; (2) engaging other relatives or secondary caregivers; (3) making decisions and taking responsibility when an older relative cannot do so alone; (4) dealing with feelings of impatience, frustration, entrapment, and guilt; (5) improving communications; (6) reducing conflict; (7) understanding the biopsychosocial changes of aging; (8) learning about community resources and (9) obtaining methods for caring for the impaired relative. (Cohen, 1983; Hartford & Parsons, 1980).

As with the other types of groups discussed, practitioners planning to conduct a caregivers group should consider the group goals, format, membership, time and size, content and focus, and termination and evaluation procedures. Caregiver groups, which often struggle with issues of loss, death and dying, and grief require knowledge, skill, and emotional investment on the part of the leader. Self-awareness is an important component for the group leader to possess. There are potential countertransference issues involved in conducting groups for caregivers particularly if the leader is in, or has faced analogous situations in his/her personal life.

Task-Centered and Problem-Solving Groups

As older persons progress through the later years, the probability that they will sustain emotional, physical and social losses increases. Most therapeutic groups are directed towards ameliorating these conditions. Old age is also a period of continued growth and development, and it follows that many elderly will welcome the opportunity to participate in task-centered or problem-solving groups. Such groups are based on the premise that a number of people with different knowledge and skills can contribute to the resolution of a problem or the completion of a task. Residence management, groups, advisory committees to area agencies on aging, planning groups for senior multiservice centers, and groups to assess community needs and social action strategies fall into this category (Hartford, 1980).

Groups which offer older adults opportunities to make ongoing contributions and to influence others serve an important function. Not only do they offer a situation in which social roles and relationships are maintained or reestablished, and contributions are acknowledged, but participants are also able to influence their environment. This is particularly true for members of social action groups who may undertake activities such as attending a public hearing or collaborating on the development and enactment of legislation.

Task-centered groups should not be thought of as limited to the well-elderly A self-government group or resident's council in a nursing home are examples of task-centered groups in which the frail and/or impaired elderly may also participate and positively affect change in their environment. The role of the practitioner in all such problem-solving groups is to foster group leadership and full participation. In that way the group can serve to enhance participant functioning and increase influence on their own lives and environment.

Sample Discussion Questions and Issues

Trainers should introduce workshop participants to selected group theories and associated techniques. Among the training exercises and discussion questions provided below there is at least one exercise applicable to each of the group work methods presented.

What are the potential therapeutic aspects of life-review for the older adult? How can participation in a reminiscing group facilitate the life-review process and enhance the therapeutic effects that may result?

Training participants can be asked to relate their own personal or professional experiences with passive vs. active group leader roles. What type of role seems to be most effective for specific client situations, i.e., grief and loss, social isolation, reminiscing, etc.?

What are the implications of Freudian vs. systems orientation in the dynamics of group process? Are they mutually exclusive?

Training participants can be divided into small groups. Each group can be assigned a different type of group process to role play the same group situation. Participants can then be brought back together to describe and report on their experiences while at the same time compare, contrast, and evaluate the dynamics of the different group processes.

When applicable, participants can be encouraged to discuss some of the difficulties they may have encountered in conducting reality orientation groups in nursing home settings, and to identify some solutions they think may be helpful.

Participants can be asked to think of personal situations that might affect their role as group leader, or example situations such as those provided below, can be presented for discussion.

> The group leader of a reminiscing group has a mother who is currently going through an intensified period of life review and the anxiety associated with the life review process. Experiencing dissatisfaction, disappointment, and anger about much of the past, the mother has been looking to her daughter, the group leader, to "make-up" for the past and meet her needs.
>
> The consultant to several nursing homes who established reality oriented milieu programs and conducts groups has recently placed her mother in a nursing home because the mother was becoming increasingly disoriented and dysfunctional.

Can participants give examples of any public policies or laws that were influenced by a group of elderly citizens? Example: The Gray Panthers.

Ask participants to describe the strengths and weaknesses of various group processes.

In what ways are clients evaluated and referred to group treatment? What constitutes which group is approprite for what client? What types of clients would not benefit from group work?

For each type of group, what outcomes can be realistically expected?

Assessing Group Work Services

This section discusses the potential outcomes and benefits of group work services with the older adult and the use of evaluation research to document the relative merits of group treatment. Issues involved in designing research questions and selecting methodology such as the use of the one-shot case study method and the one-group pretest-post-test design, are included (see Campbell & Stanley, 1963).

Potential Research Benefits

> While there are a variety of group services for the elderly population, there is agreement that some of the same group methods focus on one or more of the following purposes: the enhancement or rehabilitation of the person; improved interpersonal relationships between older people or between and among older people and their families, relatives, friends, or peers; problem-solving or achievement of tasks through collective action of elderly people; producing changes in the environment of participants in a group; designing action for changes in institutions or other organizations, creating changes in attitudes, values, social policies, programs and services by and for older people and the population in general (Lowy, 1984, pp. 21-22).

Clearly, the use of group methods for work with the aged has many potential benefits. According to Hartford (1980), groups may facilitate continued social growth, provide support through crises, and offer opportunities for rehabilitation, but their general and primary function is to positively affect mental health.

Burnside (1978) suggests that there are some important differences between group work with the elderly and work with other age groups. She proposes that group work with older people is more directive, less confrontive and more supportive than group work with other age cohorts and that this approach is necessitated by and appropriate to tasks of old age. She goes on to state that group work with older adults should provide the opportunity for teaching and listening to others, dealing with loss, death and physical disability, and alleviating general anxieties.

While there seems to be general agreement about the ameliorative and supportive factors of groups for older people, there are few systematic, well-controlled studies to measure outcome and document effectiveness. Most examples of group treatment in the literature involve samples of institutionalized persons in nursing homes, old age homes, or state mental hospitals. Therefore, it is not clear if these group programs treat behavior problems presented by residents before entering the setting, or if the focus is on the consequences of institutionalization (Zarit, 1980, p. 324). Control and comparative studies of group treatment outcomes in residential and non-residential settings are needed.

A second research problem associated with evaluating group programs for the elderly is that while virtually all studies report positive findings, they are often stated in vague terms and/or reflect measures of dubious validity. Most studies are of case situations, which limits generalizations. There are also few attempts at establishing comparison groups.

Still another problem with present studies is the lack of clarity of goals. Many groups do not have specific, well spelled-out treatment programs, making outcome measurement virtually impossible (Ibid.). It is, of course, difficult to measure multiple goals for one treatment program.

While research on group treatment for the older adult raises challenging issues, there are some valid and reliable studies that may serve as models of research design and methodology. The following three studies have been selected for that purpose.

Dye, C., and Erber, J.T. "Two Group Procedures for the Treatment of Nursing Home Patients." The Gerontologist, 21, 5 (October 1981), 539-544.

This article presents the results of a study which evaluated the effectiveness of group counseling for newly-admitted nursing home residents and their families. The newly-admitted nursing home residents (n-52) were assigned to one of the three treatment conditions as they became available--a resident-only counseling group, a resident-and-family counseling group, or a no-treatment control group. These groups consisted of seven counseling sessions occurring two times a week for a four-week period. A pre-and post-treatment battery of tests indicated that participants in the counseling groups evidenced lower self-reported anxiety and a greater feeling of internal control relative to the control group. It was concluded that such counseling holds promise for adjustment of new residents.

Hartford, M., and Parsons, R. "Groups with Relatives of Dependent Older Adults." The Gerontologist, 22, 4 (August 1982), 394-398.

This article reviews and analyzes work with groups of relatives of frail and dependent older adults. Relatives were either the primary caretakers or the responsible other for older adults who had increased dependency due to the physical frailty. The aim of the group was to provide a supportive experience and to determine whether relatives of older dependent relatives could use a group method to work on their concerns and to find relief for the problems of caretaking. It was also intended to learn the nature of the concerns of these caretaking relatives.

The authors evaluated the group experience (1) by having participants report on changes in their situation which they attributed to the group, (2) by observing participant's changes in behavior in the meeting (e.g., dress and body language), and (3) by administering the Ontario Test on Attitudes Toward Older People to participants before and after the eight sessions. They concluded that, while the Ontario Test did not show any changes for the group as a whole, the members appeared to function better and reported they had a better grasp on the situation.

Saul, S. "An Admissions Group in a Skilled Nursing Facility." Social Work with Groups, 5, 2 (1983), 67-70.

This paper describes the use of a group to help the frail elderly person during and immediately following admission to a skilled nursing facility. Within the framework of the interdisciplinary team, the group leader hopes to use the group as a means of helping the new residents cope with the difficult change in living arrangements and concurrent circumstances posed by the need for total, skilled nursing care. The author offers a taped (verbatim) record to "show how such a group serves both diagnostic and treatment purposes"(p. 67).

Suggested Training Activities

The studies referenced above can be duplicated and handed out to trainees.

Trainees can be asked to evaluate the strengths and weaknesses of each study.

Would there be value to replicating any of the studies in the participants' practice setting? If so, how would they go about setting up and conducting the study? What constraints would need to be addressed? What are the cost factors involved in conducting such research? What possible benefit could be derived from the research? Client specific? Setting specific? In general?

Summary of Practice Implications

Social group work is a method which emphasizes maximizing group processes to meet individual needs and improving interpersonal relationships. Each type of group has something special to offer, and clients should be selected for a group for which they are assessed to be most suited. Careful preplanning taking into consideration the setting, purposes, goals, and leadership of the group is also essential.

Suggested Training Activites

Trainers can provide the opportunity for workshop participants to plan a group project suited for their work setting and client population(s). The plan should spell out as many of the particulars as possible, including such factors as why each client has been selected for the group, time and place of meeting, role of the social worker, etc.

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Aronson, M., Levin, G., and Lipkowitz, R. "A Community-Based Family/Patient Group Program for Alzheimer's Disease." The Gerontologist, 24, 4 (1984), 339-342.

Alzheimer's disease may cause progressive impairment of the patient and concomitant stress on the family system. Because coping with the disease and its consequences can require much of the caregivers, group programs can be helpful as a means of support and a place to deal with feelings. This article discuses such a family group, and describes the program staffed by a psychiatrist, a psychologist, nurse practitioners, social workers, and other mental health workers.

Butler, R. "The Life Review: An Interpretation of Reminiscence in the Aged." Psychiatry, 26 (1963), 65-76.

This is a landmark article on the use of life-review in therapy. Those social workers who are not familiar with the theoretical concepts will find it useful for establishing groups for the elderly, particularly those with a life-review component.

Burnside, I. M., ed. Working with the Elderly. Group Process and Techniques. North Scituate, Massachusetts: Duxbury Press, 1978.

This collection of articles on group work with the aged is perhaps the best known book in this area. It provides information on the basics, such as membership, contracts and problems in leadership and maintenance; theoretical concepts, including principles of group psychotherapy and an approach to reminiscence; and the use of group work in "specialized" situations, such as music and art therapy and the family as a group. It also includes articles on perspectives for group work in professional curricula and experiential teaching for group workers as well as learning exercises at the end of each chapter.

Cohen, P. M. "A Group Approach for Working with Families of the Elderly." The Gerontologist, 23, 3 (1983), 248-250.

This article outlines a group approach for working with families of the elderly who were coping with the problems of caring for older relatives. Information on the format, participants, content of the group experience, group focus, and an evaluation of the group experience was provided. Group participants were thought to have received needed support and help with some of the emotional and practical problems associated with care of the elderly. Films shown included "Everybody Rides the Carousel," Part III (Pyramid Films); "Why Me?" (Pyramid Films) and "Growing Old" (McGraw Hill).

Crosby, C. "A Group Experience for Elderly, Socially Isolated Widows." *Social Work with Groups,* 1, *4* (Winter 1978), 345-353.

The purpose of this paper was to describe the process of forming, and subsequently facilitating, a short-term group for socially isolated, elderly widows who indicate that they have no friends and that loneliness has been their primary problem since the death of their spouses. Methods of recruitment and group composition, the role of the worker/facilitator, goal development and achievement, the effects of time, setting, and group size, and the worker's role in the development of the interaction process are discussed.

Feil, N. "Group Work with Disoriented Nursing Home Residents." *Social Work with Groups*, 5, *2* (1983), 57-65.

This article presents the goals, rationale, history, and some implementing techniques to help disoriented old restore dignity and self-worth in a group. The techniques focus on nonverbal helping methods. The author also presents a criterion she developed to separate the mildly confused who respond to reality orientation from the severely disoriented. Specific suggestions for setting up and maintaining the group are also provided.

Goldfarb, A. I. "Group Therapy with the Old and Aged." In H. I. Kaplan and B. J. Sadlock, eds. *Comprehensive Group Psychotherapy.* Baltimore: Williams & Wilkins Co., 1971.

The author of this article is a pioneer in psychiatric treatment for the elderly. This overview of group therapy with the aged contains an interesting discussion of the goals of therapy and psychodynamic processes. The author's theoretical stance centers on the power relationship between therapist and client.

Goodman, J. G. *Aging Parents: Whose Responsibility?* New York: Family Service Association of America, 1980.

This book is one of a series of Manuals of the Family Service Association on *Workshop Models for Family Life Education.* They are intended "to promote the exploration of new alternatives, and the utilization of new options in day-to-day living through programs in family life education. This is described as a "service of planned intervention that applies the dynamic process of group learning to improve the quality of individual and family living" (p. iii). This particular manual provides outlines and exercises for a six-session workshop on intergenerational issues, and is designed for the adult child or other responsible relative. It is well-organized and presents detailed suggestions about setting, materials and content.

Haber, D. "Promoting Mutual Help Groups Among Older Persons." The Gerontologist, 23, 3 (1983), 251-253.

This article presents brief descriptions of mutual help groups, ideas for creating them and a call for more mutual help groups among older persons and for researchers to document their extensiveness, impact, and longevity. One group described was developed at a black church and the project had three major components: (1) a 12-hour training program for church members who provided caregiving services to frail elderly; (2) staff members from the Institute of Gerontology at the University of the District of Columbia helped trainees initiate the group; and (3) an evaluation component to measure the impact of the training.

Hartford, M. E. "The Use of Group Methods for Work with the Aged." In J. E. Birren and R. B. Sloane, eds. Handbook of Mental Health and Aging. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1980, pp. 806-826.

This comprehensive article focuses on the use of groups to improve and sustain the social and mental health of older adults and examines research and theory for their useful applications. The author believes that groups may facilitate continued individual social growth through the creation of new relationships and learning, provide support through crises, offer opportunities for rehabilitation, may provide a means for collective action, and offer collective means for advocacy (p. 806). In this light, she describes the use of groups in a wide array of settings and populations such as groups for the very old and frail elderly, for those in retirement communities, and for those in need of psychotherapy.

Jewish Family and Children's Service of Baltimore. Getting the Best From the Rest. An Experiential Handbook for Senior Adult Groups. Baltimore: Author, 1978.

This family life education manual was designed to provide a dynamic group program for senior citizens and the middle-aged who need to learn about development, communication, problem-solving and improved ways of copying with the rapid changes in our society, in their families, and in themselves. It outlines eight sessions: (1) Memory, including memory exercises and "The History Line" (2) Cohort Theory and Cohort Effect, encompassing "The Life Line Exercise"; (3) The States of Man, dealing with Erikson's eight stages; (4) Physical Aspects of Aging, including diet and nutrition exercise, personal hygiene and skin care, etc.; (5) Aging and Ageism covering myths of aging; (6) Universal Human Needs and Human Motivation, discussing Maslow's Motivational Theory; (7) Looking Ahead, questioning disengagement and re-engagement; and (8) Evaluation. Copies may be ordered from JFCS, 5750 Park Heights Ave., Baltimore, Maryland 21215.

Lesser, J., Lazarus, L., Frankel, R., and Havasy, S. "Reminiscence Group Therapy with Psychotic Geriatirc Inpatients." The Gerontologist, 21, 3 (1981), 291-296.

In this report, the authors describe their experience investigating the usefulness of reminiscence group therapy with psychotic elderly inpatients at the Illinois State Psychiatric Institute. The paper also includes a survey of the literature, an examination of the theraputic role of reminiscence and a specific account of what happened in their groups. They concluded that structured reminiscence promotes group cohesiveness and fosters patient accessibility to intervention.

Levine, N. B., Gendron, C. E., Dastoor, D. P., Poitras, L. R. Sirota, S. E., Barza, S. L., and Davis, J. C. "Supporter Endurance Training: A Manual for Trainers." Clinical Gerontologist, 2, 3 (Spring 1984), 25-38.

Supporter Endurance Training (S.E.T.) is a cognitive-behavioral training program designed to enhance the coping skills of families caring for demented elderly dependents at home. Four sessions of a role-playing based group of techniques and four sessions of a meditative relaxation technique are described.

Lowy, L. "Working with Groups of Older Persons." In Social Work with the Aging. New York: Longman Publishing, Inc. 1985.

This book chapter offers a comprehensive statement of social group work practice with older adults. It discusses the primary social group work models, and offers a step by step description of the various group phases including (1) the entry phase involving the choice of group members and reaching out to individuals to become affiliated; (2) defining the task, including moving from testing toward contracting; (3) working on the task, encompassing decision-making, method and techniques; and (4) termination and separation involving the issue of closure and separation. Case illustrations make this material come alive.

McNeil, J. S., and King, S. W., eds. Guidelines for Developing Mental Health and Minority Aging Curriculum, with a Focus on Self-Help Groups. Washington, D. C.: National Institute of Mental Health, January 1984.

This series of five chapters provides information pertinent to developing a social work curriculum for the minority elderly with a focus on self-help. Chapter one is a course syllabus on developing self-help groups among minority elderly; chapter two discusses teaching a course in social welfare policy and the elderly; chapter three examines social work research/evaluation for minority aging; chapter four deals with field instruction for students learning to work with black and Chicano elders, and chapter five discusses evaluating the self-help minority aging program.

Mellor, M. J., Rzetelny, H., and Hudis, I. B. "Self-Help Groups for Caregivers of the Aged." In S. L. Abels and P. Abels, eds. Social Work with Groups. Proceedings 1979 Symposium. Louisville, Kentucky: Committee for the Advancement of Social Wrok with Groups, 1981, pp. 270-285.

This article on self-help groups for the caregivers of the aged uses case examples to discuss a "self-help continuum for groups." The continuum ranges from the professionally-led group in which there is "no self-help" to those with a nonprofessional leader or no leader with the "most self-help." The case histories which illustrate the utilization of the continuum and the role of the leader/facilitators, provide examples of groups with populations with diverse socioeconomic status.

Miller, I., and Solomon, R. "The Development of Group Services for the Elderly." Journal of Gerontological Social Work, 2 3 (Spring, 1980), 241-257.

This article covers a lot of ground and provides an indepth overview of group work with the older adult. The authors contend that group services for older people can make an important difference in mitigating feelings of loneliness and helplessness and in providing opportunities for continuity of social roles and for the development of new ones. They provide information on (1) formal and informal educational groups, (2) life tasks, or problem-solving groups, (3) self-government groups, and (4) social action groups. They also discuss the helping process in groups accoring to the phase of work: the initial phase (preparation), the beginning, the ongoing phase, and the termination phase.

Petty, B. J. "Support Groups for Elderly Prsons in the Community." The Gerontologist, 16, 6 (December 1976), 522-528.

A detailed presentation is made of the techniques used in four community based support groups for elderly persons experiencing moderate stress as a result of the aging process. The support groups were structured as informal workshops that were presented over ten two-hour sessions. Group leaders provided objective information about normal changes in the later years and helped clients develop more effective interpersonal skills to cope with these changes. Pre-and post-test results indicated that the majority of clients experienced decreased anxiety about the aging process, became more effective in problem-solving, and began to make use of community resources (p. 522).

Pincus, A. "Reminiscence in Aging and Its Implications for Social Work Practice." Social Work, 5 (July 1970), 47-53.

This early article on the relevance of life-review to social work practice with the elderly offers a discussion of the benefits of reminiscing for intrapersonal and interpersonal functioning. It is important reading for those social workers not familiar with the life-review process as a possible group format.

Stabler, N. "The Use of Groups in Day Centers for Older Adults." Social Work with Groups, 4, 3/4 (Fall/Winter 1981), 49-58.

This paper describes groups used as the treatment of choice in a day center for older adults. It utilizes a framework of four group categories (discussion groups, therapy groups, disability-specific treatment groups, and leisure time/life skills groups) that have been developed and adapted to serve the needs of the impaired elderly population in a rehabilitation oriented day center. The author supports the use of groups as "social treatment and supplies examples of a number of group interactions as evidence of the effectiveness of group treatment for older isolated people" (p. 49).

Weisman, S., and Shusterman, R. "Remembering, Reminiscing, and Life-Reviewing in an Activity Program for the Elderly." Concern (January 1977), 22-26.

This article discusses the use of reminiscence in an activity program for the elderly in a long-term care institution. The programs, designed to work on the developmental tasks of aging, include group activities such as art therapy, music therapy, poetry, and dance therapy.

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APPENDIX A

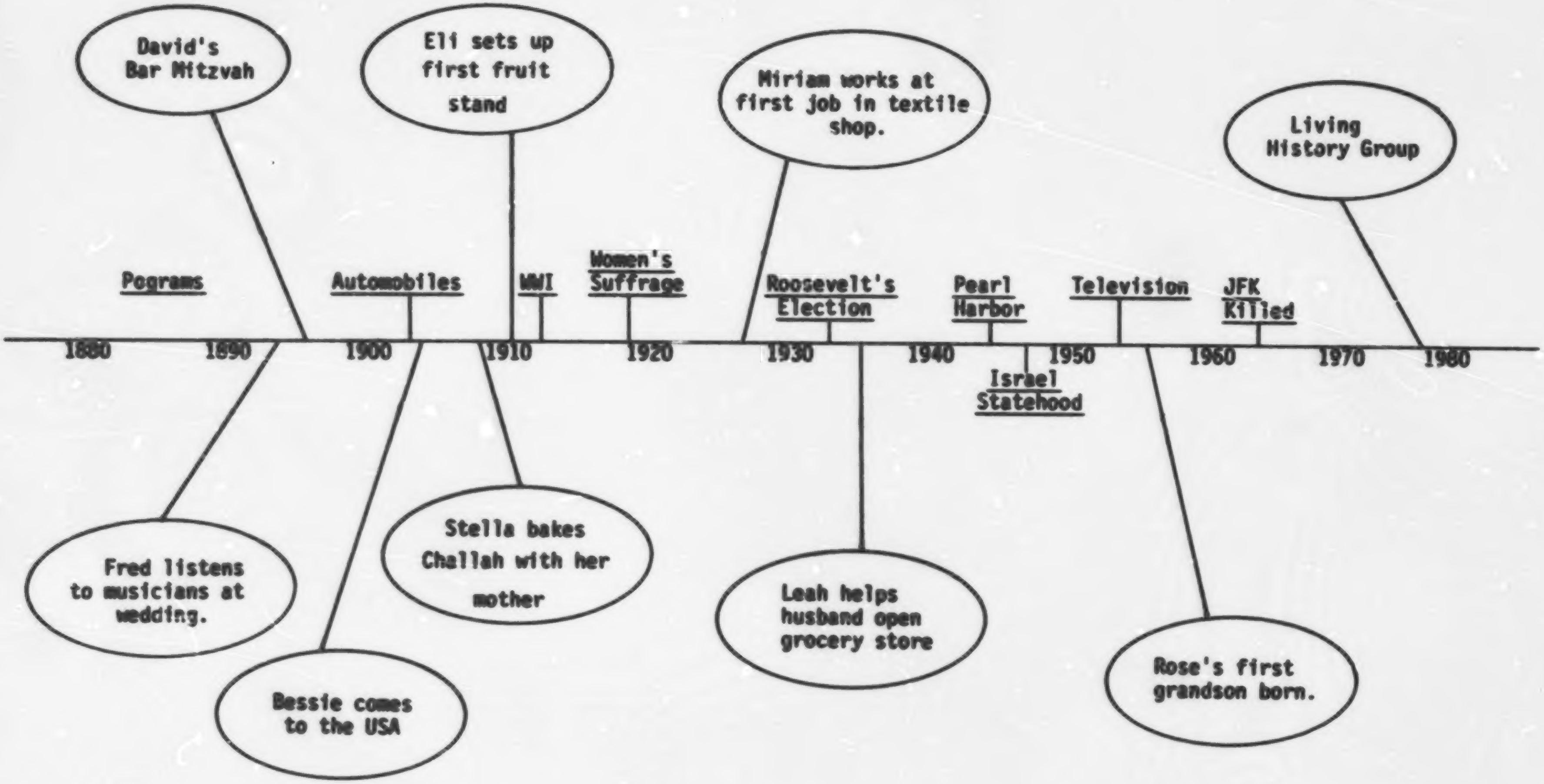
Special Components with Contribute to the Formation of the Social Work Group

Component	Specialized Requirement Related to Worker	Specialized Requirement Related to Group
Purpose	Differentiated helping purpose for worker.	Differentiated group purpose under professional auspice.
Relationships	Professional norm for acceptance in worker-member relationships. Professional norm for respect in worker-group relationship.	Norm for open relationship system - norm for acceptance, tolerance of difference in member-member relationship. Norm for mutual aid.
Structure	Professional norm for activation of group autonomy. Professional norm for constraining worker power. Professional norm for activation of democratic group processes.	Norm for open communication system. Norm for open, flexible role system. Norm for democratic group functioning.
Operation	Professional norm for worker mediation in group interaction.	Norm for effective participation. Norm for participating together. Norm for development of technical competence of members for agenda-processing. Norm for productive work.
Content	Professional norm for worker mediation in interaction between content, group process, and indivdual members.	Norm for open, flexible program content forms and range.

Lang. N. "Some Defining Characteristics of the Social Work Group: Unique Social Form." In S. L. Abels and P. Abels, eds. Social Work with Groups Proceedings 1979 Symposium. Louisville, Kentucky: Committee for the Advancement of Social Work with Groups, 1981.

APPENDIX B

Example of a Timetable


David's Bar Mitzvah
Eli sets up first fruit stand
Miriam works at first job in textile shop.
Living History Group
Pograms
Automobiles
WWI
Women's Suffrage
Roosevelt's Election
Pearl Harbor
Television
JFK Killed
1880
1890
1900
1910
1920
1930
1940
1950
1960
1970
1980
Israel Statehood
Fred listens to musicians at wedding.
Bessie comes to the USA
Stella bakes Challah with her mother
Leah helps husband open grocery store
Rose's first grandson born.

Journal of Gerontological Social Work. 2, 4, (Summer 1980).

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SEXUALITY IN LATER LIFE

The sexuality of older adults is often subject to misconception and misinformation. Stereotypes and myths suggest that sexuality is not a part of the interests, behaviors, and abilities of the elderly. This module focuses on sexuality as a normal lifelong function and provides information about age-related changes in sexual physiology and performance. Techniques for recognizing and supporting the special developmental issues of sex and intimacy that occur in the later years are reviewed.

Content covered in this module includes:

- Sexuality in the older adult as the continued expression of a normal aspect of human behavior;
- Negative societal attitudes toward older people as sexual beings;
- The major research studies that document that older persons continue to engage in sexual activity;
- The major age-related physiological changes that may affect sexual functioning;
- Incorporating sexual counseling into the casework process;
- Policy issues affecting the freedom of sexual expression in nursing homes.

Training objectives include:

- Increased knowledge of the sexual issues and concerns of elderly clients;
- Increased recognition of normal physiological changes;
- Enhanced ability to diagnose sex-related problems and sexual dysfunctions, as evidenced by:
    - Increased interview content on sexual issues,
    - More frequent inclusion of sexual issues in the treatment plan;
- Wider knowledge of medical referral sources for elderly clients with sexual dysfunction problems;
- Greater knowledge of nursing home policies that impact upon sexual behavior of older clients;
- Increased knowledge of social attitudes and the way they affect sexuality in older people.

Defining Sexuality

The goal of this section is to explore sexuality in older adults as a multi-dimensional phenomenon that has both psychosocial and physiological components.

Definitions

> Intimacy is "the ability to experience an open, supportive, tender relationship with another person without fear of losing one's own identity in the process of growing close" (Newman & Newman, 1979, p. 516).
>
> ". . . the nature of love and sexual intimacy between older lovers has less to do with intense excitement and more to do with tenderness, affection, understanding, touching, warmth and physical closeness. Love and sexuality in the later years are an affirmation of present aliveness and past shared experiences" (Reedy, 1978, p. 194).
>
> Sex in later life is sex for its own sake: pleasure, release, communication, shared intimacy. . . . Older people have, in fact, a special ability to bring love and sex to new levels of development literally because they are older. They develop perceptions which are connected with the unique sense of having lived a long time and having struggled to come to terms with life as a cycle from birth to death" (Butler & Lewis, 1976, pp. 136-145).
>
> ". . . human sexuality encompasses more than sexual intercourse. Intimacy may be manifested in many ways, from listening, conversing, holding hands, to giving a hug or gift" (Greene, 1986).

Sexual expression in late adulthood, as at any age, is a reflection of many psychosocial and physical influences, and its manifestation is affected by factors such as cultural mores, cohort effects, sexual history, physiological capacities, and partner availability (Comfort, 1980; Corby & Solnick, 1980). Thus essential for practitioners working with the older client is a review of sexual attitudes and stereotypes, a clarification of misconceptions, a presentation of physiological age-related changes directly and indirectly related to sexual functioning, an understanding of the effects of disease, the psychosocial aspects of sexuality, and archaic regulations in nursing homes. In family and individual treatment, the resistance on the part of adult children to their parents' sexuality may also have important implications.

Suggested Training Activities

Trainers should be aware of the potential discomfort of participants in discussing sexual content and acknowledge this with participants. It may facilitate discussion to begin with a broad definition of sexuality in which participants are helped to appreciate that human sexuality encompasses more than sexual intercourse and that intimacy may be manifested in many ways from listening, conversing, holding hands to giving a hug or gift.

Social Attitudes: Sex and Age

In this section societal attitudes about the "sexless older years" are examined. Sexuality in the aged has often been a source of humor and/or disdain. Because of pervasive stereotypes of sex as only an activity and concern of the young, the exploration of one's own attitude is essential. Jokes, cartoons, or references to TV skits, such as those seen on the Carol Burnett show in which two elderly people sit in their rocking chairs and "dare to touch," can be used as triggers for discussion. The following joke is such an example: "Definition of old age: When you know you love your wife, but can't remember why."

Attitudes and Stereotypes

> Many people, young and old, are astonished at the idea of human beings making love in their seventies, eighties, and even beyond. It is assumed that (1) older people do not have sexual desires, (2) they could not make love even if they _did_ want to, (3) they are too fragile physically and it _might_ hurt them, (4) they are physically unattractive and therefore sexually undesirable, and (5) anyway, the whole notion is shameful and decidedly perverse (Butler & Lewis, 1982, p. 140).

Such attitudes, in which older people are viewed as either sexless or degenerate, have had widespread influences: researchers are reluctant to investigate sexuality among older people; clinicians are often reluctant to address this issue in therapy; and older people often view themselves as unattractive and undesirable.

In her article "Age Kills Us Softly," Genevay (1978) maintains that professionals need to begin to see the older people with whom they work as sexual beings. She suggests a number of questions to assist in that process, and to open our eyes to new sexual options for our clients as well as ourselves:

Questions

(1) What does "old" mean to you? What picture do you see?

(2) In what ways do you affirm and give permission for other people to be themselves, to widen their sexual options? (Be aware of your eyes, body movement, tone of voice, words, hesitance, body stance.)

(3) How have you learned to accept your body--to be at peace with the body in which you live--so you can relax with your own limitations, and enjoy your own sexuality and that of others?

(4) What are your strengths in helping other people who are at war with their bodies _re-own_ the parts of their bodies, minds, and feelings that they've disowned with aging?

(5) Do you have difficulty in touching older people? In what ways do you touch them, and what does it mean to you? (Sensory? Affectional? Sexual? Other?) Do you ask the other person what the meaning is for them, so communication is clear between you?

(6) What fears--if any--are you in touch with when you relate to someone of a different sexual preference than your own? In what ways do you attempt to see the person behind the sexual preference?

(7) How do you nonverbally honor or dishonor the sexual preferences of people who are: ugly, heterosexual, asexual, attractive, gay, lesbian, disabled, bisexual, ill? (Add other "categories" of people that blind us to personhood.)

(8) In what ways do you think about--and affirm--your own parents' sexuality, if you do? How does this affect your openness to older people's sexuality, and to your own?

Suggested Training Activities

In order to deal effectively with the topic of sexuality and aging, workshop participants must be given an opportunity to understand their own attitudes.

Trainees can be asked to close their eyes and visualize their own conception. The trainers can then ask them to contemplate a series of questions that no one is expected to answer aloud.

> What did you see? Location--room, bed, decor, etc.? People--faces, bodies, clothing? Activity--touching, kissing, position, etc.?

Trainers can ask participants to stand up when the description given applies to them.

> I am too tall, too fat, too short, too skinny. My breasts are too small, too big. My penis is too small, too big. My nose is too long, too small. Fantasized effects of aging can be included, e.g., my body is too wrinkled, I feel I am no longer "sexy."

Appendix B contains the "Adult Sexuality Knowledge and Attitude Test" (ASKAT) that can be reproduced entirely or in parts and given to training participants to facilitate self-awareness about their sexual attitudes.

Research on Sexuality

In this section, the three major research studies on sexuality and aging are critically examined. Issues of sample size and representativeness as well as the differences between longitudinal and cross-sectional studies are addressed.

Research

The breadth, adequacy, and validity of research on sexuality and aging is far from adequate. Gerontologists who have either studied or attempted to synthesize the available data and information on this topic speak of "biased samples," "misinformation," and a "lack of any real knowlege" about what older people do or think about sexually, about what sexual changes occur with age, and about what is "normal" or "not normal" in old age (Comfort, 1980; Ludeman, 1981; Solnick & Corby, 1983). Nonetheless, Zarit claims that "from the studies that have been conducted on sexuality and aging, one fact has clearly emerged--healthy older persons who want to maintain their sexual activity into their 80s and possibly beyond are able to do so" (Zarit, 1980, p. 377).

The data which have documented this fact, until recently were based on small, nonrepresentative samples, and taken from three major nationally known studies. It is important to know of both their shortcomings and research contributions of these studies:

1. While the aged are underrepresented in the Kinsey Study (1953), it can be considered "a pioneer in modern-day studies of sexuality in the aging. . ." and the findings useful in refuting the idea that older people are asexual. In a study of 106 men and 56 women over 60 (total n = 14,084), Kinsey et al. found that most men at age 60 were "sexually capable and that there was little evidence of sexual decline in women until late in life. However, they also reported a gradual decline in frequency of sexual intercourse between ages 20 and 60. Availability of sexual partners and the frequency of sexual intercourse are factors which affect this data (see Butler & Lewis, 1982; Kinsey et al., 1953; Pfeiffer, 1977).

2. Masters and Johnson (1966) based their research data on laboratory observations of sexual performance and interviews with a group of self-selected aged subjects (39 men aged 50 to 90 and 34 women 40 to 80). In general, they found that men past age 60 were slower than younger men in sexual responsiveness due to physiologic age-related changes, while women experience minimal functional changes. They suggested, however, that those elderly who are more sexually active in their younger years are likely to continue to be sexually active in old age.

3. The Duke Longitudinal Study which has been carried out every three years since 1954 and is still in progress, is considered the best source of longitudinal data on sexual functioning. It explores somatic, psychological, and social changes associated with old age as well as

data on past and present sexual activity. Because the subjects (250 people between the ages of 60 and 94) were seen at three-year intervals, it was possible to observe changes occurring within individual subjects over time, not merely changes in groups of subjects, as in the case of cross-sectional studies (Pfeiffer, 1977).

The study explored questions related to the degree of enjoyment of sexual intercourse and intensity of sexual feelings among intact couples. Information was gathered on the present frequency of intercourse, and on the reasons for and age of cessation of coital activity for those who are no longer sexually active. Reports (Pfeiffer, Verwoerdt, & Wang, 1968, 1969) suggested that men tend to become less sexually active with advancing years, but remained sexually interested. The major reason women gave for ceasing sexual activity was the death or illness of their husband, or because he had lost interest or potency. Two major conclusions were reached: Sexual interest and sexual intercourse are by no means rare in persons over the age of 60, and patterns of sexual interest and activity differ substantially for men and women of the same age.

While the study is not as well-known, the most up-to-date information on sexual activity and responses in the later years can be found in Brecher's 1984 report Love, Sex and Aging. Data were gathered during 1978-1979 and are based on a national voluntary sample of 4,246 women and men aged 50 to 93.

Sample Discussion Questions and Issues

How do these findings "fit" with the stereotypes?

Can these findings "be trusted"? Would older people perhaps not openly discuss their sexual activity?

Might the increasingly liberal sexual attitudes and recognition and validation of sexuality throughout the life cycle contribute to increasing the sexual activity of the elderly? How? Through "permission", image, expectation?

Human Behavior Theory and Sexuality

This section outlines the human behavior content required to assess sexual dysfunction in the older adult. It is suggested that case studies need to encompass health and sexual histories as well as psychosocial influences.

Human Behavior

> There is no doubt that physiological changes occur as a person ages. There is, however, some question as to how much these changes influence sexual behavior, since it is very difficult to separate physiological and psychological effects. For this reason, it is important to bear in mind that the existence of physiological change does not, in itself, mean that sexual functioning will be affected detrimentally (Corby & Solnick, 1980, p. 893).

As with all aspects of human behavior, sexual functioning is affected by the complex interaction of biopsychosocial factors. For this reason, practitioners should be prepared to discuss with their clients normal age-related sexual changes as well as the older person's feelings and possible misunderstandings about them.

While the sexual functioning of women has not been well-documented, available data suggest that they experience fewer physiological changes with age than do men. Among the most common changes are a thinning of the vaginal walls, which can cause cracking, bleeding, pain, burning, and/or itching, a reduction in the length and diameter of the vagina, and an increase in sensitivity in the urethra and bladder. However, if a woman is in good health, she can expect to continue to experience sexual activity until late in life. As women usually outlive men, the unavailability of "sexual partners" can become an issue. Ludeman (1981) reports that "while masturbation has been reported as an alternative or an adjunct to coitus for some older women, homosexuality and bisexuality have not been seen generally as an acceptable sexual outlet" (p. 206).

Major physical characteristics associated with sex in older men include, among other factors, an increase in the amount of time required to reach full erection, an inability to remain erect for longer periods of time, and a reduction in the intensity of the ejaculatory process. Men's fear of declining sexuality can contribute to sexual problems. However, older men do not lose their facility for erection unless physical or emotional illness interferes.

There are many disease-related conditions which have the potential to affect sexual functioning. Of particular note are heart and circulatory disease, diabetes, prostatectomy, colectomy and ileostomy, mastectomy, hysterectomy, and orphorectomy, urinary infections and alcoholism. Other factors to be considered are prescribed medications such as tranquilizers (see appendix in this module), boredom, fatigue, depression and fear of failure (Butler & Lewis, 1982; Comfort, 1980; Corby & Solnick, 1980).

Because sexual expression is so varied and complex, an assessment of sexual dysfunction can only be made by giving full consideration to psychosocial factors. In short, the client's health and sexual history can only be understood in light of the psychological and cultural meanings he/she attaches to his/her experiences. The practitioner who is aware of the potential effects of chronic physical impairments on sexual interest and activity can play an important role in helping clients continue to find a means of sexual expression when disabling conditions occur.

Sample Discussion Questions and Issues

Because of the discomfort with the topic of sex, trainers should consider how to allocate sufficient time to both content and to value clarification. A question about how younger practitioners feel about engaging in a conversation about sex with an older client may open discussion.

What questions would a practitioner ask in an interview to elicit the degree of sexual activity experienced by an older person?

If there is lack of sexual activity or sexual dysfunction, what questions would elicit information on potential sources of the problem?

Trainees an be asked to role play interviews:

(1) with an older couple experiencing sexual problems, an elderly man suffering a recent onset of impotency, the wife's response to the husband, e.g., she may be angry/non-supportive. How does the practitioner help them within the context of the marital relationship and its history?

(2) with a woman who has suddenly become involved in a relationship with a younger man and is having fears and questions about the sexual aspect of the relationship and her children's negative reactions to it.

Direct Practice Implications

In this section, the translation to direct practice of knowledge about sexuality in the older adult is considered, including the incorporation of sexual counseling/education into the therapeutic process.

Method

> Sexual counseling and therapy depend almost wholly on permission-giving and the correction of false or irrational attitudes towards sexuality. Sexual counseling in the old also involves the correction of false and irrational attitudes toward aging. . . . The role of the geriatrician is to foster the sexual response as a supportive and enriching part of continued experience without impertinent proselytizing (Comfort, 1980, pp. 888-891).

As has already been stated, negative cultural attitudes and physiological changes can negatively affect the sexual functioning of older adults. Whether or not these individuals obtain help depends not only upon their willingness to seek assistance, but also on the practitioners' readiness to address sexual issues in therapy. Therefore, it is important for practitioners to develop sufficient expertise in treatment methods to comfortably include this area of counseling in their casework repertoire.

A major mental health treatment consideration is sex education. Normal age-related changes need to be understood so that they are not mistaken for a loss in sexuality. Techniques of sexual intercourse that are especially pertinent to the older adult are also germane. Another important task is to help clarify for the client, often in conference with other medical personnel, when sexual activity may be resumed following an illness or surgery.

In addition to being able to incorporate sexual counseling into the casework process, the practitioner may also want to develop further expertise in running a sexual therapy program. Sviland (1978), who describes a sexual therapy program specifically tailored for helping elderly persons become sexually liberated, concludes that sexual therapy can "enable elderly couples to open mutual communication, to increase intimacy and self-esteem, and to enjoy without guilt the sexual pleasures that society restricts to its youth" (p. 112).

Sample Discussion Questions and Issues

(See Steffl (1978) for specific issues and questions for discussion.)

What steps are involved in setting up a sexual therapy program? How are clients recruited? What are the issues? Who defines them?

Institutional Care and Sexual Expression

This section explores the conflict between freedom of sexual practices and administrative policies in long-term care institutions. Specific case examples are used to evaluate the potential role of the practitioner, e.g., how do you counsel "the dirty old man" in the nursing home (see Steffl, 1978)?

Policy

While sexual activity is most often thought of as a private and personal matter, there are those elderly for whom this fundamental assumption cannot be made--the nursing home patients. Sexual practices and administrative policies in long-term care institutions have long come under question.

Miller (1978) suggests that "in this era of increasing emphasis on patients' rights, the administration of long-term care institutions will need to develop policies regarding sexual practices of inpatients, including homosexual and heterosexual activity between brain-intact and/or brain-damaged residents" (p. 164).

It is important for the practitioner to recognize that there are many interested and affected individuals and groups that in some way are involved with the subject of sexual activity in the institutional setting: patients, families, owners and board members, volunteers, professional and nonprofessional staff, friends of patients, government surveyors, citizen consumer groups and personnel from the Joint Commission on Accreditation of Hospitals. Therefore, the older person usually is not in control of his/her own decisions regarding means of sexual expression.

Sample Discussion Questions and Issues

A case example, "Home for Adults in Liverpool Forbids Sexual Expression," is provided in Appendix A. This case vignette can be used for discussion, or trainees can be asked to provide case examples from their own practice experience. Practitioners employed in nursing homes should think about where they stand on this issue, and consider what their role may be in supporting the rights of the older patient.

What are the attitudes of the trainees on the freedom of sexual contact within institutional settings? How might these attitudes impact on policy-making? Should they? If not, how does one separate their own values and preferences from the rights of others?

Summary of Practice Implications

Because of the powerful role sexual behavior plays in the life of most people, it seems obvious that this issue would be addressed in counseling with older adults. Despite the fact that there may be a need for sexual counseling and that older people may have concerns about their sexual functioning, this subject is often ignored. It has even been said that the two topics practitioners are least likely to discuss with an older adult are death and sex.

During each decade since 1890 sexual attitudes and practices have become more liberal. It has been hypothesized that one can almost suggest what a person's sexual attitudes are based on age, education and occupation. Older persons were socialized during an era when people were generally less open to issues of sexuality. As a result, many older clients continue to have misconceptions and fears about their sexuality and to suffer sexual dysfunctions. This cohort effect on sexual behavior in older adults is often difficult to separate from the aging process itself. However, as discussed elsewhere in this material, it should be remembered that attitudes and behavior can change at any developmental stage in the life cycle.

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Brecher, Edward M. and the Editors of Consumer Reports. Love, Sex, and Aging. Mt. Vernon, NY: Consumers Union, 1984.

This book provides a large-scale data set on sexual activity and responses in the later years. It reports on a national, voluntary sample of 4,246 women and men aged 50 to 93. Data were gathered during 1978-1979.

Butler, R.N., and Lewis, M. Aging and Mental Health. St. Louis, MO: C.V. Mosby & Co., 1982.

This text provides an excellent overview of topics related to aging and mental health. The chapters on organic brain disorder, diagnostic evaluation, and drug and electroshock therapy will be most useful for those who wish to keep abreast of these topics. The discussion on sexuality in old age is brief, but offers the kind of straightforward information the geriatric caseworker will find useful.

________. Sex After Sixty: A Guide for Men and Women for Their Later Years. New York: Harper & Row, 1976.

This book is intended to refute the myth that older people are asexual beings. Rather, it discusses the normal changes that can occur with aging, and how partners can continue to enjoy their sexuality. It makes the point that "sex does not merely exist after sixty: it holds the possibility of becoming greater than it ever was. It can be joyful and creative, healthy and health-giving. It unites human beings in an affirmation of love."

Comfort, A. "Sexuality in Later Life." In J.E. Birren and R.B. Sloane, eds. Handbook of Mental Health and Aging. Englewood Cliffs, NJ: Prentice Hall, Inc., 1980, pp. 885-892.

This article reinforces the fact that sexual activity can continue on into old age, and that the persistence of sexual function most often depends on psychosocial issues. The author points out that sexual problems in later life include those which can occur at any age, and deserve supportive and positive attention in the counseling relationship. Suggestions are made for counseling of sexual dysfunction in older patients and for the management of organic impotency.

Corby, N., and Solnick, R. "Psychosocial and Physiological Influences on Sexuality in the Older Adult." In J.E. Birren and R.B. Sloane, eds., Handbook of Mental Health and Aging. Englewood Cliffs, NJ: Prentice Hall, Inc., 1980, pp. 893-921.

This book chapter provides an overview of the major concerns related to human sexuality and aging. It includes information on sexual activities, physiological changes, biopsychosocial influences on sexual behavior (e.g., disease, prostatectomy), sexual dysfunction, interventions and special populations (e.g., elderly homosexuals and the institutionalized elderly). There is also an excellent list of references.

Kaas, M.J. "Sexual Expression of the Elderly in Nursing Homes." The Gerontologist, 18, 4 (1978), 372-378.

The author first discusses the limitations on sexual expression of the elderly brought about by cultural restrictions and taboos. She then reports the results of a study to compare differences between elderly nursing home residents and nursing home nursing staff in attitudes toward sexual expression of the elderly. While in general both groups "accepted" sexual expression of the elderly, there were many negative "clues" given about this topic; e.g., a majority of the residents stated they did not feel sexually attractive any more.

Masters, W.H., and Johnson, V.E. Human Sexual Response. Boston: Little, Brown & Co., 1966.

In his summary of the extensive research done by Masters on the changed physiology of sexual expression in the later years, Pfeiffer (1978) makes the following comments: ". . . basic findings are extremely encouraging. First there appears to be no biologic limitation to sexual capacity in the aging female. While there are substantial changes in the male, they do not contribute substantially to a diminution of satisfactory sexual expression in aging men." With the exception of specific existing diseases, physiologic changes do not ring a mandatory curtain on sexuality in either aging men or aging women.

Pfeiffer, E., Verwoerdt, A., and Wang, H.S. "Sexual Behavior in Aged Men and Women. I. Observations on 254 Community Volunteers." Archives General Psychiatry, 19 (1968), 753.

This is one of a series of reports from a longitudinal interdisciplinary study of older persons that has been carried out since 1954 at the Duke University Center for the Study of Aging and Human Development. Initially, 254 subjects, ranging in age from 60 to 94 years and roughly equally divided between men and women, were studied. Included in the study panel were 31 intact couples who provided the investigator with an opportunity to cross-validate the information provided by each of the two marriage partners. Two major conclusions were reached: sexual interest and coital activity are by no means rare in persons beyond age 60, and patterns of sexual interest and coital activity differ substantially for men and women of the same age. Sexual expression should be considered in the overall context of successful aging.

Rossman, I. "Sexuality and Aging: An Internist's Perspective." In R.L. Solnick, ed. Sexuality and Aging. Los Angeles: University of Southern California Press, 1978.

This article outlines some of the difficulties the physician may face in understanding and diagnosing sexual diffculties among the aged. Dr. Rossman provides practical information about particular illnesses and their relationship to sexual activity. For example, he points out that "if a postcoronary patient can climb two flights of stairs without significant or disabling symptomatology, there is no reason for forbidding sexual activity." This article provides useful information for the geriatric caseworker who can play a critical role in educating clients and making necessary medical referrals.

Solnick, R.L., ed. Sexuality and Aging. California: The University of Southern California Press, 1978.

This compilation of readings, which is available from the Ethel Percy Andrus Gerontology Center, offers a wide range of articles ranging from the physiology of sexuality in aging to sexual practices and administrative policies in long-term care institutions. It could serve as a "text" for a class or workshop on sexuality and aging.

Sviland, M.A.P. "A Program of Sexual Liberation and Growth in the Elderly." In R.L. Solnick, ed. Sexuality and Aging. Los Angeles: University of Southern California Press, 1978.

The author discusses the cultural stereotyping and myths on aging and sexuality. She clarifies misconceptions by providing information on the current knowledge of sexual behavior in the elderly, and restrictive cultural and physiological factors limiting elderly sexuality. Suggestions are made for sexual therapy to help the elderly become sexually liberated including: assessment, granting permission to be sexual, working through obstructive marital dynamics, enhancing direct communication, increasing physical attractiveness, sex education, increasing eroticism and fantasy life, selected sexual exercises, and techniques and changes to minimize effects of aging in the male.

Wascow, M., and Loeb, M. "Sexuality in Nursing Homes." In R.L. Solnick, ed. Sexuality and Aging. Los Angeles, CA: The University of Southern California Press, 1978.

This is a report of a research project conducted by the University of Wisconsin-Madison School of Social Work. Research students were trained to interview the 27 male residents, 35 female residents and 17 staff members. They found that residents of nursing homes in general believe that sexual activity is appropriate for other people. However, most of them are not currently personally involved because of the lack of opportunity. The staff of the nursing home were found to be permissive in their attitudes but were frequently distressed by acting-out behaviors.

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Minnie Remembers - 16 mm film/Color - 5 minutes, 1975.
Available from: Mass Media Ministries. Rental: $12.50.
Purchase: $125.00

This short film is based on the poem "Minnie Remembers" by Donna Swanson. Minnie, an old woman, sits all day in her rocking chair and reminisces about her past. Minnie tries to remember the last time someone touched her. In her 20 years of widowhood, she has been respected, smiled at, but never touched! The ultimate tragedy, the loss of one's identity, is beautifully portrayed in this short yet poignant film.

The Golden Honeymoon - 52 minutes, 1980.
Noel Black, director.

Ring Lardner's story of a fiftieth wedding anniversary "honeymoon," in a humorous yet touching manner, exemplifies how we never stop growing. Charley and Lucy's outing turns sour when Lucy meets an old suitor whom Charley treats as a new rival. Although in the end the Tates' love for each other is strengthened, the insecurities and jealousies that are exhibited suggest that our development never stagnates.

Rose By Any Other Name - 15 minutes, 1976.
Judith Keller, producer.

This film illustrates the loving relationship between an aging pair in a nursing home, the reactions of others to it, and the pressures that arise to end its "unseemliness." It sensitively explores the elderly's need for closeness, privacy and love.

APPENDIX A

Home for Adults in Liverpool Forbids Sexual Expression

As a social worker employed by the State Department of Social Services with responsibilty for licensing homes for adults, last winter Marion Bernard conducted a semi-annual review of the Richmore Resthome for Adults located in a small town, Liverpool, in a north central state. He was told indirectly that the administration of the home was about to implement a policy that would make sexual relations between the residents forbidden except between married couples. Residents were most concerned and dismayed over these upcoming plans and felt helpless to do anything about it. Although most residents found it difficult to speak openly, two outspoken individuals stated that they were worried about bed checks and other measures that the staff would use to enforce the policy, and they felt that their privacy was being invaded. This home had no written policy pertaining to sexual activity among residents, and it was generally considered to be a private matter which should be kept in the privacy of a person's own room and did not infringe upon the rights of others.

General Background

Richmore Resthome for Adults has been operating for 15 years and is privately owned. While most residents are elderly, there is an open policy for any individual who needs shelter or minimal assistance in their daily lives. Consequently, the age range of residents is from 35 to 80, with a few individuals mildly retarded and three couples that have actually decided to retire in this home. The home is now owned by a group of medical doctors who purchsed this enterprise three years ago. They hired a business manager who was the former director of the Christian Children's Home in a nearby city. From Marion's observations, it appeared that this director has very sincere fundamentalist religious beliefs and may be trying to impose a religious code on the policies of the home. The home itself is in good repair and generally clean and comfortable. As usual, the food is a focus of complaint, but no one appears to be malnourished.

Marion's experience in social work began as an eligibility worker after completing his baccalaureate degree in English at the University of Iowa. After four years, he then attended graduate school in social work and concentrated his studies on casework with children and families. Upon graduation, he worked for a child guidance clinic in a large urban area for seven years before taking a position with the State Department of Social Services in their licensing division. He has enjoyed working with the elderly, and he hopes to concentrate more of his efforts and energies towards this population as time passes.

The State Department of Social Services has had a very uneven reputation. Sometimes people believe that the welfare workers represent the worst form of oppression, and in other instances, particularly in areas of abuse, they provide a service that no other agency can do. This ambivalence has caused many professional workers to reassess their involvement in state social services work.

The community of Liverpool is a small (20,000) town with two major industries: 1) leather gloves and 2) a major trucking crossroads.

Fact Finding

Marion did several things. He checked with his supervisor regarding the State Department's policy regarding sexual expression. There was no policy. A few weeks later, he met with the administrator of the home to investagate the rumor and discovered that indeed the home was going to impose a policy forbidding sexual expression. The question was answered, and the conversation ended as the administrator straightened her shoulders and coldly replied, "I am not running a brothel here, and I do not want the town to hear about this. By law, young man, I have the right to determine if sexual activity will be allowed in my home. My secretary will see you to the door."

Marion was stunned by the finality of the administrator's statement, but he informally contacted a group of concerned professionals who had introduced a year ago a Code of Ethics bill for adult home operators to the General Assembly which included a clause regarding sexual expression. The bill had been defeated, but the group still continued to exist and offered Marion support in pursuit of a resolution of this problem.

Marion decided confrontation would not be a workable strategy and he developed an education program regarding the emotional needs and feelings of older persons. He obtained the permission of the administrator of the home to allow this seminar to be conducted in her conference room for other professionals in the area. However, the administrator did not actually attend the session.

Marion also wanted to encourage the residents to organize themselves in order to appeal to the medical doctors, the owners. He suggested an informal meeting which began calmly enough, but soon erupted into a series of emotional outbursts, catching him off guard. The general theme of distress was expressed by Tim Murphy who announced indignantly that he felt he had "to sneak around like a damned kid!" To which Paul Carson added, "If this is considered my home and I'm paying money to stay here and not causing trouble, why can't I do this here? I certainly would in my own home. It just isn't fair!"

Nevertheless, Marion knew from the outset that the residents felt vulnerable. There were few housing alternatives for the residents if the home wanted to turn them out because they were troublemakers.

Planning for Change

Marion had set a self-imposed deadline of two weeks after the seminar meeting for his next move. He knew he had some momentum going with several members of that group, and he did not want to lose whatever advantage he had gained with them. It was not just the strong fundamentalist religious views that were prevalent in Liverpool, but the problems of ageism and public apathy regarding the rights and needs of the elderly that he had to consider. What was the best way to use key persons in the community who could influence change? What were the attitudes and degree of commitment towards freedom of choice among the home's owners? What forms of social action were appropriate for this particular community? Could his own agency serve a leadership role? Marion had much to consider as his deadline neared and he began to formulate his strategies for change.

* * * * *

Authorship of vignette: Linda Evans, Charlotte Syran.

Source: R.L. Schneider, T. Decker, J. Freeman, and C. Syran. A Curriculum Concentration in Gerontology for Graduate Social Work Education. Washington, DC: Council on Social Work Education, 1984, 70-72.

SOCIAL POLICY AND CHANGE AND THE ELDERLY: ADVOCACY AND EMPOWERMENT

The purpose of this module is to increase participants' awareness of the political/policy implications of providing human services to the elderly. In the first section content focuses on social policy as an integral part of direct practice. The second section outlines two intervention strategies for effecting social change: advocacy and empowerment.

The content of this module includes:

- The role of policy decisions in all aspects of social work service provision;
- The importance of practitioner participation in the policy arena and ways in which practitioners can be more directly involved in policy decisions;
- Selected current social policy issues in gerontology;
- Methods of intervention (advocacy, empowerment) that address issues of social inequities and macrosystem problems.

At the conclusion of this training participants will be able to:

- Cite relevant social policy/legislative issues affecting the aged and the nature of services provided to the elderly;
- Evidence increased knowledge of social policy concepts that can be applied in direct practice with the elderly;
- Cite examples of recent policy decisions that reflect social attitudes about the elderly in this society;
- Demonstrate how empowerment and advocacy can be used to address gerontological social policy issues;
- Exhibit knowledge of current social policy issues affecting the elderly.

Definitions

Social policy as a philosophical concept is the principle whereby members of large organizations and political entities collectively seek enduring solutions to the problems that affect them.

Social policy as a product consists of the conclusions reached by persons concerned with the betterment of community conditions and social life and with the amelioration of deviance and social disorganization.

Social policy as a process consists of actions by which organizations maintain an element of stability and at the same time seek to improve conditions for their members.

Social policy as a framework for action is both product and process. It assumes the availability of a policy that is to be implemented within the context of potential changes in the values, structure, and conditions of the group affected.

(Freeman & Sherwood, 1970, p. 3, as discussed by Lowy, 1980, p. 5.)

Societal Perspectives on Aging

This unit focuses on political/policy issues in gerontology. It presents materials intended to foster interest in broader societal concerns and to increase the practitioner's knowledge of the historical/social milieu in which practice takes place. Topics to be covered offer a varying perspective on aging issues in the political arena and include:

1. Age-grading, age segregation and ageism

   Age-grading refers to the way in which society classifies people by age. It is a process of prescribing and evaluating what is considered appropriate behavior and allocating rights and responsibilities by age group. Age-grading is a form of social control and is an important element in shaping one's personal views of his/her "social utility." As such, it can be a powerful force in shaping a person's life (Kastenbaum, 1979).

   Age segregation refers to the existence of homogeneous environments and the degree to which there is social interaction across age groups. A key issue has been whether publicly sponsored housing should be age-segregated. Also of concern are the large numbers of elderly persons concentrated in inner city areas with inadequate housing and other services, posing particular difficulties for the minority aged who live on incomes below the poverty level.

   Ageism refers to negative or pejorative image of and attitudes toward an individual simply because he/she is old. Such negative valuation of the aged is often subtle but places them in a disadvantaged position.

2. Changing age-dependency ratios

   Age-dependency ratios are a demographic measure of the changing age composition in a particular population. Since it is based on an aggregation of those considered either too young or too old to contribute to their own financial well-being, the age-dependency ratio indicates how many dependents every 100 working members of a society must support (Hendricks & Hendricks, 1977). The competing needs of the young worker versus the older retired person are currently of concern to those examining contributions to the Social Security System.

3. Roleless role

   Roleless role is a term used to describe the ambiguity many find characteristic of retirement when there may be few explicit expectations regarding actual behavior or performance. This sense of discontinuity is said to be greatest for individuals who are forced to retire. Mandatory retirement (and attitudes toward older workers) are of growing political interest as the number of older people increases and the job market "needs more room for younger workers." This may be particularly the case in some technological societies in which the older person faces rapid obsolescence of knowledge and skills.

Sample Discussion Questions and Issues

What does society define as appropriate behavior for the elderly? How do these stereotypes affect an aged person's self-image, opportunities?

What are the advantages and disadvantages to age-segregated communities?

Identify the issues of concern currently surrounding the Social Security System. What alternative systems of support for the elderly might be developed?

What are the participants' ideas about intergenerational equity?

What are the participants' views on mandatory retirement; on the roles for the elderly in the work force?

Social Policy and the Aged

> The phenomenon of aging, with its ensuing personal, social, and political consequences, has received more formal attention by public policy makers in the last decade than at any previous period. . . . Our social policies toward the aging have moved toward selective assumption of societal responsibility and away from reliance on exclusive kin or filial responsibility, toward acceptance of rightful entitlement of benefits rather than dependency on charitable supports that are stigmatized and toward more institutional services geared to meet individual requirements rather than residual, undifferentiated services (Lowy, 1980, p. 7).

While federal public social policy for the aged in the United States is a relatively new phenomenon, there is nonetheless a significant body of legislation relevant to the work of practitioners as well as the lives of the elderly. These include the Social Security Act of 1935 and its many amendments, Medicare, and the Older Americans Act of 1965 and its amendments.

Despite the progress that has been made, there are still many gaps in services and an insufficient allocation of funds and resources for the elderly. How these needs are to be met during a time of cutbacks, scarce resources and the priority of balancing the federal budget is a matter of utmost concern. Many of these issues have been identified by the delegates to the 1981 White House Conference on Aging and other policy experts (see appendix).

While few practitioners would consider themselves part of the policy arena, this is far from the case.

> Practitioners, be they social workers, nurses, allied health professionals, or social planners, by their actions are not merely implementing social policies, they are, in fact, enacting social policies themselves. This awareness is of crucial importance to the conduct of every practitioner's

> behavior. The practitioner directly involved in the provision of services to clients can play an important role in the formulation of and is instrumental to the execution of the policies that guide service organizations. In practice, the separation of policy formulation from execution is a delicate division; aware and experienced practitioners often exercise considerable discretion in executing board directives and thus shape as well as discharge the requirements of organizational policies (Lowy, 1980, p. 1).

The practitioner who "goes the extra mile" to deal with agency red tape is affecting policy (see the discussion of advocacy later in the module).

Because the enactment of new legislation may affect the benefits and services available to elderly clients, the practitioner is invariably involved in policy decisions. A case in point is the problem of the DRG (diagnosis-related groups) system. The system, established as a cost-containment measure by the Social Security Act Amendments of 1983, changed Medicare's reimbursement method from one based on the actual cost of a patient's care to one based on the average costs of treatment for a particular diagnosis. Under this system, hospitals that treat patients for less than the predetermined cost can keep the savings, but must absorb the loss if treatment cost exceeds the fixed amount. This has affected hospital discharge planning and overloaded long-term care services, with negative implications for patients. Hospitals have been accused of "dumping out" patients whose charges have reached the amount reimbursable under the DRG.

According to the NASW News of April 1985, social workers have quickly responded to the negative effects this policy initiative has had on their clients.

> A coalition of 25 groups led by NASW, which opposes a revision of Medicare regulations for hospitals, has called repeatedly for a study of the DRG system's impact on patient care before any more changes are made in Medicare. A number of members of Congress shared the coalition's concern, and pressed HHS officials for further information about the way "less prescriptive" hospital rules may affect care delivery (p. 1).

Suggested Training Activities

While providing participants with the foundations of public social policy as it relates to the aged is certainly beyond the scope of any one workshop, leaders may want to offer summary information pertaining to federal benefits to the aged. (For an example, see the Federal Register of April 1, 1985, which presents an update of interim final regulations for the Title III and Title IV programs under the Older Americans Act.)

The issues identified by the delegates to the 1981 White House Conference on Aging (Appendix A), which may be said to constitute a policy agenda for the 1980s, can be used to open discussion. However, it is suggested that more specific and timely topics, which may affect current practice and draw participants into debate, be selected for major emphasis. At this time, that might include the significance of the federal budget's cutbacks and proposed changes in Social Security.

Appendix B provides a list of 30 policy issues regarding older Americans that can be used for discussion.

Because of the impact of policy decisions on service delivery, workshop topics most likely to appeal to practitioners are those that provide a better understanding of this phenomenon, and suggest a line of action that can be taken in response. Topics might include DRGs (see Appendix C for NASW News article), forced retirement, and intergenerational conflict in policy formation. While such current issues make for excellent workshop discussion, leaders should be careful to include the history and provisions of the legislation in question for those participatnts who may not be familiar with them.

There is a wealth of information available on the policy making and implementing process (see annotated bibliography). The Congressional Research Service, the Social Security Administration, the American Public Welfare Association, and private think tanks--e.g., The Brookings Institution, The Heritage Foundation--are several of the most up-to-date sources. For example, the Social Security Bulletin (February 1985) contains a special report on "Women and Social Security." It presents findings from the Social Security Administration's New Beneficiary Survey about average social security benefits, other pension receipt rates, marital status, and number of children raised by women entering retirement in the early 1980s. It also presents projections for the year 2030 of average benefits for all married, widowed, divorced, and never-married women and men aged 62 or older. Such materials, including tables and easy-to-read graphs, can be used in planning a workshop on policy related to women's issues.

Advocacy as Macro-Intervention

The goal of this section is to explore the use of advocacy in alleviating problems that negatively impact on a large number of the elderly. The individual, the administrator and the policy aspects of advocacy are introduced.

> An advocate is one who defends, promotes, or pleads a cause. In this role, the worker acts as a partisan in a social conflict and uses professional expertise in the interest of the older client (Harbert & Ginsberg, 1979, p. 234).

> An advocate "organizes activity designed to obtain goods, services, power, or other resources for client(s)" (Biegel, Shore, & Gordon, 1984, p. 42).

> Advocacy is an attempt. . .by an individual or group to influence another individual or group to make a decision that would not have been made otherwise and that concerns the welfare or interests of a third party who is in a less powerful status than the decision maker (Sosin & Caulum, 1983, p. 13).

Advocacy

> Sound functioning in an individual or community requires among other things, the ability to master the environment and to influence positively the forces affecting that ability to cope. In simple language, this may be conceptualized as power. Lack of power or powerlessness and helplessness are the root causes of poor social functioning and of the disorganization in people and in the systems that surround them. . . . If our institutional response and problem-solving endeavors are directed to the elimination of that powerlessness, then we are truly "starting where the client is. . ." (Pinderhughes, 1976).

Questions of advocacy and empowerment cannot be addressed without first raising the issue of power. While it is more usual to think of power as being expressed in "outright" discrimination and/or in conflict, it may also have more subtle dimensions. Powerlessness in its fullest sense refers to the "inability to manage emotions, skills, knowledge, and/or material resources in a way that effective performance of valued social roles will lead to personal gratification (Solomon, 1976, p. 16). It relates to a societal process by which groups, types, or classes of people are made to feel "hopeless, helpless, limited and/or expendable" (Goldenberg, 1978).

Solomon (1976) suggests that "there are some individuals or groups whose exposure to negative valuations has been so intense that they accept these valuations as 'right' or at least inevitable and therefore make no effort to exert power at all" (p. 21). Minority group members, as can be true of the elderly in general, are often in this situation. Both advocacy and empowerment are methods of intervention designed to ameliorate that condition.

Advocacy is an intervention strategy that is concerned with the balance of power between the client as a member of a minority or other disenfranchised group, and the larger society. The advocate generally takes action to rectify unfair and/or unjust practices and the inequitable distribution of resources (Green, 1982). From the advocate's point of view, the client's problems are not seen as psychological or personal deficits, but rather as stemming or arising from discrimination in social and economic opportunities (Dodson, 1981; Prunty, 1980). Therefore, techniques of intervention, rather than focus solely on the relief of individual clients, challenge those systems' inequities which contribute to or cause difficulties. This is a macro system intervention. Advocacy on behalf of one or more implies that the condition or problem has ramifications of a broader nature (Harbert & Ginsberg, 1979). For example, insufficient income is a problem facing a large proportion of the elderly. While practitioners frequently struggle to get financial assistance for the older adult on a case-by-case basis, they rarely take larger measures such as testifying before boards or legislative bodies regarding the overall need for more adequate income supports for the elderly. (See Kleinkauf, 1981, for a guide to giving legislative testimony.)

Advocacy, as the preceding example illustrates, can occur at three levels: the individual level, the administrative level and/or the policy level. At the individual level, advocacy focuses on the manner in which a specific client or group is assisted in a specific situation such as the acceptance of a client for service; administrative-level advocacy is centered on convincing decision-makers to alter agency regulations such as the verification procedures used in public welfare; while policy-level advocacy seeks to influence legislators to change regulations and laws such as social security provisions. "To negate advocacy on any level is to dismiss a basic tenet of social work practice" (Sosin & Caulum, 1983, p. 15).

In short, advocacy as an approach to intervention requires the recognition that many clients

> have serious social system problems and have spent a great deal of time, effort, energy and resources in trying to cope with them. They have waged a losing battle. As an advocate, an individual social worker must first, therefore, shift the focus, even if it means going to the other extreme of refusing to see any emotional problem at all, and deal specifically with the more reality-oriented problem that they [the clients] bring (Prunty, 1980, p. 183).

An important goal of advocacy is to influence clients to organize on their own behalf. Therefore, it should be stressed that older people can and more frequently do act as their own advocates, and are beginning to take positive steps to overcome their powerlessness and exclusions (Harbert & Ginsberg, 1979). A classic example is, of course, the Gray Panther Movement. The AARP is another example of an organization that exerts an extremely important legislative advocacy force.

Sample Discussion Questions and Issues

Workshop participants may gain a better appreciation for the role of the advocate by examining cases from what Prunty (1980) has termed the "case-to-cause" perspective. "This response moves caseworkers out of the one-to-one and into another arena, one specifically related to advocacy, because it concerns a given problem that has been identified by a number of clients" (p. 183). Here, the practitioner is interested in collecting information about a number of cases with similar problems and ameliorating them through macro systems intervention. The way in which this can be accomplished in a particular agency may serve as the focus of discussion.

Training participants can also provide case examples from their practice, to which macro system intervention can be applied.

Why are the practitioners who directly provide services not more involved in broader advocacy activities on behalf of their clients? What are the impediments: lack of time, skills, knowledge, priorities?

Power and Control

The aim of this section is to review and explore the power differential and control issues that may exist in the worker-client relationship. Potential difficulties in providing a service which maximizes client effectiveness and feelings of self-worth are noted.

> Empowerment is "gaining an ability to manage emotions, knowledge, skills or material resources in a way that makes possible effective performance of valued social roles and receipt of personal gratification. Empowerment as process refers to a set of activities aimed at reducing institutionally derived powerlessness. . .caused by. . .social injustice and societal inconsistency" (Bush, Norton, Sanders & Solomon, p. 103).
>
> Empowerment refers to a process whereby persons who belong to a stigmatized social category [throughout their lives] can be assisted to develop and increase skills in the exercise of interpersonal influence and the performance of valued social roles. . . . When considered as a process, empowerment refers to the development of an effective support system for those who have been blocked from achieving individual or collective goals because of the severity or complexity of the discrimination they have suffered" (Solomon, 1976, pp. 6, 21-22).

Empowerment

> Powerlessness may be an issue to some extent with all clients who come to help settings, and all problem-solving strategies need to take into account the degree to which powerlessness is derived from the experience of systematic negative valuation based upon membership in a socially stigmatized category (Solomon, 1976, pp. 22-25).

To the extent that powerlessness may be at issue with every client who seeks help, empowerment may be viewed as a necessary component of all human service methods and techniques. Empowerment as a goal of practice assumes that the knowledge and skills that the practitioner uses in working with the client [system] will be beneficial in the problem-solving process. It involves providing help in such a manner as to give maximum opportunity for clients to experience their own effectiveness. In short, the interventions taken encourage the client to participate in the helping process and "to redefine his self-worth, competence and ability to affect his social and physical worlds" (ibid., p. 342).

While the goal of empowerment may at first glance seem relatively easy to attain, it is, in fact, difficult to achieve. Unfortunately, many agencies designed to assist the poor and the powerless may actually hold power over their clients, rather than encourage them to exert it. As in any service provision, agency personnel and policies determine what services are available to whom and under what circumstances.

In order to receive services from a public agency, a person must be determined to be eligible by income and financial resource criteria as well as age or other eligibility factors. Often clients feel they have no choice as to who provides services or when services are given. At the same time, social workers may encourage and reinforce the clients' dependency rather than contribute to their sense of autonomy (Solomon, 1976).

Recent empirical studies have demonstrated that there is often little consensus between practitioners and clients on such important matters as the definition of the problem, what interventions are needed, and the goals and outcome of treatment. These studies have also shown that such issues can remain areas of contention throughout the relationship. In addition, many current intervention approaches to problem-solving tend to ignore the impact of the organizational environment in which problem-solving takes place. Murdoch (1982) maintains that these forces often make clinical problem-solving "a political act by which the participants seek to accomplish a more satisfactory redistribution of power and control" (p. 418). She goes on to suggest that by recognizing the omnipresence of conflict in social relationships (including helping relationships) the practitioner can consciously adopt strategies to maintain balance in the client-worker relationship and to control the effects of power discrepancies (p. 420).

There are a number of projects that have employed the concept of community empowerment in providing services for the elderly. The Neighborhood and Family Services Project of the University of Southern California/Washington Public Affairs Center and the Mutual Aid Project (MAP) of the Citizens Committee for New York City are examples. Biegel et al. (1984) suggest that these intervention strategies, that build on community strengths to overcome identified obstacles to service delivery, are based on a concern for capacity and equity. Capacity is based on an "individual's or group's ability to utilize power to solve problems, gain access to institutions or organizations that serve them, and provide nurturance to others." Equity refers to "whether individual or groups define their investment as equal to their return, and whether they see themselves as getting their fair share of resources as compared to others" (p. 137). From this perspective, intervention strategies are aimed at increasing the capacity and equity of elderly persons and mobilizing the necessary resources--political, economic, and attitudinal--to meet these needs.

Sample Discussion Questions and Issues

Because practitioners working with the aged often deal with frail and/or impaired clients, the danger of infantilizing or "taking over the client's affairs" is always present. Workshop participants may wish to discuss case examples in which they have encountered difficulties in maintaining empowerment as a practice goal. The following case examples can be given to training participants for discussion.

Homemaker service for Mr. C. may only be available on Wednesday afternoons due to high overall demand for the service and scheduling conflicts. Mr. H. needs a homemaker more than one half-day per week or he may have a regularly scheduled appointment for physical therapy on Wednesday afternoon.

Mrs. B. prefers to sleep during the day and be awake at night. She usually watches all-night movies. Since she has been living at the nursing home she is not allowed to sleep during the day and is given sleeping pills when she remains awake at night. Mr. W. prefers to eat dinner at 7:00 p.m. However, the nursing home serves dinner at 4:00 p.m. because of staffing schedules.

What are the results of such bureaucratic and institutional requirements and procedures? Are they necessary? How can service providers be more responsive to clients' needs while still managing an efficient operation? As a worker in either setting, would you consider advocating any changes? If so, how would you go about it? If not, why?

Summary of Practice Implications

Human service workers, particularly those in direct practice, often fail to see how the day-to-day provision of services involves political decisions. As a result, they tend to minimize their potential political influence or power in decision-making. The practitioner who perceives her/himself as powerless in this regard is not likely to acknowledge that therapy/casework can be viewed as a political act. However, there are those who believe the helping relationship has many political implications (Edelman, 1974; Prunty, 1980). By this they mean that there is unnecessary labeling of clients as emotionally or mentally ill and a refusal to recognize that many people have serious social system problems.

The practitioner who takes a systems approach and is accepting of his/her role as change agent is more likely to assist clients in pursuing solutions that thelp change or ameliorate oppressive social and economic circumstances and to work to make institutions more responsive to clients. They will also see the need to share their experience as "front-line" workers with boards of directors, funding agencies, and legislative bodies.

Sample Discussion Questions and Issues

As the need to take a more active political stance may not be a point of view shared by all workshop participants, trainers may want to elicit case examples from those who have been more politically active in their agency or community. Examples of clients who have become active on their own behalf and/or those who have received much sought-after benefits as a result of their own or the workers' efforts are most useful.

Equally valuable for discussion are cases which may suggest both counseling or intrapsychic interventions as well as systems interventions.

A number of recent newspaper articles provided in Appendix D exemplify some current policy issues regarding the elderly and can be used for discussion purposes.

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American Public Welfare Association. This Week in Washington, March 29, 1985, Vol. VI, No. 13.

This Week in Washington is published 50 times a year by the American Public Welfare Association and may be ordered through Publication Services, 1125 Fifteenth Street NW, Washington, DC 20005. The newsletter contains short reports on legislative matters related to human services and health legislation. This particular volume reports on the elderly poor and the effects of freezing social security benefits in FY 86, the clean bill of health for Medicare trust fund, and plans to introduce legislation to shore up federal food assistance.

Bell, W.G., Schmidt, W., and Miller, K. "Public Guardianship and the Elderly: Findings from a National Study." The Gerontologist, 21, 2 (1981), 194-202.

The basic question in this research is: To what extent do current provisions in state public guardianship laws assist or hinder elderly persons in attaining their individual rights, benefits, and entitlements? A review of statutes in 34 states including on-site visits led the author to conclude that the continuation of public guardianship is necessary if less restrictive alternatives are developed and adult protective services strengthened. A model statute on public guardianship is proposed.

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This is a thorough well-written practice-oriented book on social network intervention with the elderly. The authors first researched and collected information on existing programs and models that address the social support needs of the aged. A typology was developed to organize and systematize this material and make it useful for agency practitioners. As a result, seven types of network intervention progams are described: clinical treatment, family caregiver enhancement, case management, neighborhood helping, volunteer linking, mutual and self-help, and community empowerment.

Committee for Economic Development, Program Committee. Social Security from Crisis to Crisis. Washington, DC: Committee for Economic Development, 1984. Mailing address: 1700 K Street NW, Washington, DC 20006.

This position paper written in response to "the specter of insolvency" in the Social Security System makes recommendations for future policy. It recognizes the inherent uncertainties of economic and demographic projections on which past social security policies have been based and provides excellent graphic summaries.

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Five work-related programs--those that base eligibility for benefits and size of benefits upon work histories and earning records--are covered by this study. This includes social security, Medicare, civil service retirement, military retirement, and railroad retirement. This is a comprehensive, easy-to-read study with many excellent graphs and charts.

Congressional Research Service, The Library of Congress. Up-Date Washington, DC. March 1985 c/o Library of Congress, Washington, DC 20540. Call (202) 287-7904.

This government bibliography and lists of information, products and services is published monthly and contains a description of hundreds of background reports on current major topics. These include such topics as budget and government spending, civil rights and liberties, communications, environmental protection, health, housing, income maintenance, minority issues, veterans' benefits and services, and social services. There is also a CRS STATS LINE which is a recorded message giving current figures for selected economic indicators such as the consumer price index, federal deficit and unemployment rates.

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"Unfortunately, many elderly accept the status quo of medical care delivery, and health professionals tend to exclude them from both the community process and policy issues." This paper suggests an innovative group structure and process for integrating health care providers and elderly consumers in community health care planning, implementation and evaluation. The Elderly Health Advocacy Group, which involves elderly consumers and service providers as collaborative participants in a "consensus model" is described and its developmental processes outlined (see also Ehrlich, P., Elderly Health Advocacy Group: Handbook of Organizing Principles. Springfield, IL: Department of Public Health, 1980).

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In this book, the author addresses several thought-provoking questions concerning the status, effectiveness and social consequences of public policies and services for the aged. Some of those discussed include: What do current social science perspectives contribute to understanding the problems of the elderly? How much do older persons really benefit from programs designed to help them? How do popular and professional attitudes toward aging influence public policy? How does public policy in this area reflect the broader power structure of American society? It makes for interesting reading.

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This paper is an attempt to provide some insight into the question of whether the rate of service utilization among the rural elderly is comparable to that of urban aged. The study of 5,700 non-metropolitan elderly revealed only slightly higher rates of service utilization for urban versus rural residents. Marital status, income, and age were related to service use for both groups. Among the rural aged, lack of transportation was also related to service usage. Additional correlates of service use among the urban elderly were car ownership and education.

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This article raises the issue of "deregulation and privatization" in nursing home inspection, and examines the role of patient advocacy in working against "the erosion of federal oversight." The authors suggest that an analysis of national survey data on nursing home ombudsman programs documents three alternative formulations of advocacy subscribed to by constituent groups in the long-term care network: (1) individualized/developmentally-focused, (2) individualized/patients' rights-focused, and (3) facility/patients' rights-focused. The perspectives analyzed vary according to one's position in the long-term delivery network.

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This analysis of private pensions from the Brookings Institution will be useful to the social worker who wishes to have a better grounding in the economics of pension plans. It contains chapters on "Federal Tax Provisions and the Development of Private Plans" and "The Future of Private Pensions."

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The author maintains that public policy analysis for the elderly concerns itself almost exclusively with direct expenditure programs for the elderly. It seldom examines tax relief measures for the elderly. This article examines federal tax expenditures or subsidies directed toward enhancing the retirement income of the elderly. Such expenditures annually target tens of billions of dollars in benefits to the wealthiest segment of the elderly population. Also examined are the equity issues posed by these findings and recommendations made that these tax expenditures be examined on a case-by-case basis with direct expenditures for the elderly.

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"The United States relies more heavily than most nations (even industrialized ones) on its market system in the belief that the economy is best served by a large private sector with only limited government influence on resource allocation and pricing decisions" (p. 29). This monograph from the Committee for Economic Development, a national think-tank, explores the economics of policy formation in a clear-cut, easy-to-read fashion. Chapters include "Recommendations for Screening, Adopting and Designing Government Action" and "Weakness in the Current Policy-Making Process."

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This article asks how should scarce medical care resources be allocated among the aged, the middle-aged, the slightly-aged, and the young. That is, when the care of the elderly imposes emotional and financial burdens on others--family, society, the middle-aged population--should the elderly be treated with less vigor for similar medical problems than, say, the middle-aged and the young? The author suggests that a decision should be made by taking into account a correct perception of the medical indications, an appreciation of the patient's values and preferences, an evaluation of the patient's quality of life and an awareness of external considerations such as the role of family and the cost of care.

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APPENDIX A

Agenda for Social Policy on Aging

A series of social-goal statements identified by older persons and their organizations, by professionals working in the field, and by political leaders constitute the agenda of our social policy on aging that will certainly continue to surface during the 1981 White House Conference. These social goals include:

1. Assurance of an adequate income for every older person through a federally administered system of income security that is protected against inflation, devaluation of the dollar, and pension loss.

2. Reduction or abatement of federal, state, and local taxes for older persons and also a reduction of rates of public utilities such as transportation, telephone, gas, electricity, and so forth.

3. Reorganization and reordering of the physical and mental health delivery system with stress on case finding, early detection, treatment, rehabilitation, prevention, group practice, and home assistance; development of an all-inclusive prepaid national health-insurance system to remove financial worries and to assure cost control.

4. Provision of increased public social services divorced from financial needs.

5. Development of additional social and community services that would include many additional social services for older people and for research and demonstration projects leading to newer or improved programs to aid them.

6. Increase in older persons' housing options in urban and rural areas and eligibility of single persons for moderate-income and rental housing that is now available only to couples; in addition, automatic inclusion of a battery of social services in all public-housing projects designed for the elderly.

7. Inclusion in national service-programs opportunities for older people who are able and willing and in a position to provide services for people with problems in all age groups.

8. Expansion of the Manpower Development and Training Act and Area Development Act to help older workers and those in the middle years make the best possible use of training opportunities in communities and to prepare for second careers.

9. Provision of a pool for part-time employment opportunities for older people and preretirement counseling services sponsored under industry, management, and labor.

10. Increase in the federal contribution for the building of long-term-care facilities, provision of more uniform standards for nursing homes, and provision of more uniform quality standards for nursing-home care with enforcement possibilities. Removal of institutional stigma from institutions for the aged who are chronically ill.

11. Development of increased geriatric treatment facilities for the mentally ill and disabled and halfway houses for those who are released from hospitals and mental health institutions.

12. Provision of a continuum of home health services and medical care services for the physically ill as well as the mentally ill in their own homes or homes of relatives.

13. Provision of an increased program of foster and boarding care for the elderly.

14. Development of day-care centers, recreation centers, and outreach programs for those who cannot take advantage of existing recreational facilities.

15. Increase in educational and cultural opportunities under adult education and cultural auspices.

16. Development of a more uniform program of accessible social services, particularly homemaker, health aides, protective, consumer information, legal assistance, friendly visitor, meals-on-wheels, and multiservice centers.

17. Creation of nutritional programs coupled with social, educational, and recreational services to improve the nutrition of older people and to assist in alleviating incipient personal problems.

18. Provision of improved transportation facilities to counteract physical isolation and to advance the mobility of older persons.

19. Development of short-range and long-range plans by all professions and organizations (governmental and nongovernmental, including older people themselves) that would provide for the well-being of the elderly in all walks of life, taking into account that the aged are not a homogeneous group and creating opportunities for individual choices.

20. Expansion of research projects and facilities and provision for the utilization of research findings as soon as possible in planning and development of social-welfare programs and services.

21. Development of new, and improvement of existing, educational and training programs for professionals, paraprofessionals, nonprofessionals, and volunteers working with the elderly, linking the formal with the informal network of services.

22. Development of a system whereby the existence of projects can be readily communicated to the public and where the results of successful demonstration projects can be made part of programs and services as quickly as possible.

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APPENDIX B

Thirty Policy Issues Regarding Older Americans

Overall Issues

1. What should be the future policy direction of the aging policy in the USA--a concern with the quality of life in old age or cost considerations of such programs as Social Security, Medicare, Medicaid, etc.?

2. Should aging policy be centered on the needs of the "old-old" or the "young-old" or both?

Health Care

3. Should there be a means-test in the Medicare Program?

4. If not, should current beneficiaries be asked to contribute more through the use of increased deductibles and coinsurance?

5. What gaps, if any, in the Medicare Program should be closed over the next four or five years--prescription drugs, long-term care, in-home services, other?

6. Should a system for long-term care services be established? If so, how would it be administered and financed? Through Medicare and/or Medicaid? The Older Americans Act? A separate federal-state program?

7. What should be done by both government and the voluntary sector to meet the growing demand for better mental health services by older people?

8. What governmental action is needed to improve the quality of the nation's nursing homes?

Income

9. Should a means-test be used in Social Security to avoid paying benefits to the affluent and rich elderly?

10. Should Social Security benefits continue to be "indexed"? If so, how?

11. Should the various Social Security trust funds be removed from the unified federal budget? Also, should the Social Security Administration be administered by an independent agency under the direction of a bipartisan board appointed by the President with the consent of the Congress?

12. What can be done to improve the Social Security Program for women workers? Should some form of modified earnings sharing system be developed?

13. What can be done to improve the income status of older and disabled widows who are already retired and/or unable to work?

14. What public policies are needed to bring the older poor out of poverty? Could the Supplementary Security Income Program be the mechanism for such an objective?

15. Should the retirement age of 65 be restored in the Social Security Program for those workers scheduled to retire in the year 2009 or later?

16. Should we hold the scope of Social Security protection constant in future years, and instead, encourage greater use of such devices as IRAs and deferred compensation plans as the major sources of retirement income for most workers?

Employment

17. Should more authority and funding be given to the Equal Opportunity Commission to more effectively carry out the mandate of the Age Discrimination in Employment Act?

18. Should the Older Workers Specialist Program be re-established in the federal-state employment service system, so that older workers are more effectively used in the nation's labor force?

19. How, and in what ways, if any, should the Title V Senior Employment Program under the Older Americans Act be expanded, so that more low-income unemployed older people can participate in the program?

Older Americans Act and Social and Community Services

20. Should the Older Americans Act continue to be looked upon as the focal point for the development of coordinated planning and services for older people at the federal, state, and local community levels?

21. Should the Older Americans Act be converted into a block grant program? If so, why?

22. Should the existing "aging network" be given the responsibility for the development of a community-based system of long-term care services?

Housing

23. Should there be further federal, state, and local governmental efforts to encourage greater housing options and alternatives for older people than now exist? If so, what options and alternatives should be stressed?

24. Should the existing Section 202 Program and other subsidized housing for the low and moderate income older population be phased out and replaced with a housing voucher and/or rent supplemental system instead?

25. Should life care and continuing care homes be given a priority over other approaches to housing by the federal government and or state government?

Education

26. What could be done to broaden the educational opportunities available to older people by various governmental levels?

27. What could be done by variuos public educational systems--higher education, secondary education, and elementary education--to help provide a better understanding of aging and older people in our society?

Research

28. How well has the National Institute on Aging (NIA) performed its responsibilities? What could be done to improve the work of NIA?

29. What could be done to improve the work of the Center of Aging of the National Institute of Mental Health? What could be done to improve its work?

30. What additional research in aging should be encouraged by public policy makers?

APPENDIX C

Hill Panels Find DRGs Leave Patients "Sicker"

NASW News, Volume 30, Number 4, April 1985

The Capitol Hill committees on aging are taking their first look at how Medicare's new prospective-payment reimbursement system is affecting the quality of hospital care, and the diagnosis thus far appears unfavorable.

Studies done for the Senate Special Committee on Aging and the House Select Committee on Aging indicate that larger numbers of patients are being discharged in poorer health since the system took effect, and suggest that post-discharge care providers may be unable to meet the increased demand.

The system, established as a cost-containment measure by the Social Security Act Amendments of 1983, changed Medicare's reimbursement method from one based on the actual cost of a patient's care to one based on the average costs of treatment for particular diagnoses. Thus, it has become known as the DRG (diagnosis-related groups) system.

Under the system, hospitals that treat patients for less than the predetermined cost can keep the savings, but must absorb the loss if the treatment cost exceeds the fixed amount.

A coalition of 25 groups led by NASW, which opposes a proposed HHS revision of Medicare regulations for hospitals, has called repeatedly for a study of the DRG system's impact on patient care before any more changes are made in Medicare. A number of members of Congress shared the coalition's concern, and pressed HHS officials for further information about the way the "less prescriptive" hospital rules may affect care delivery. They asked HHS not to publish final rules until questions about their effects are resolved.

At a hearing held February 26 by the House commitee and its Task Force on the Rural Elderly, one of the coalition's members, the American Association of Retired Persons, testified that the "increased flexibility" proposed in the rules could be used by hospitals "to hire unqualified staff and to cut corners in services so that they can compensate for the monies they fear they will lose under the prospective-payment system." AARP noted that the proposal applies mainly to some 1,500 rural hospitals but, if adopted, could prompt national accrediting bodies that certify more than 5,000 other hospitals for Medicare participation to adopt standards less stringent than those now in force.

NASW also wrote testimony for submission to the committee on the coalition's behalf. It said that imposing new Medicare rules before the effect of the DRG system is fully understood "would cause too many changes too quickly, and the victims of the resulting chaos would be patients and the quality of care they receive."

At the House hearing, Rural Task Force Chairman Mike Synar (D-Okla.) said attention to the DRG system thus far "has been focused primarily on cost containment" rather than on quality of care. The task force therefore surveyed all state nursing-home ombudsmen to determine the effect the system is having on post-hospital care.

According to Synar, of the 75 percent who responded to the survey, 77 percent said "patients are being discharged sicker or much sicker than before" the system took effect, and 71 percent said "more or many more" people are now in need of skilled nursing care after discharge. More than half of those responding said "existing skilled nursing care is not adequate to meet the needs of discharged patients in rural areas," and a third said care was "inadequate in urban areas." Synar added that 59 percent said rural-area nursing homes did not have adequate staff to provide care before, and 67 percent "believe it isn't adequate" now.

"This survey clearly shows that health care in rural areas is inadequate, and changes in Medicare are making it worse," Synar said. "Yet the administration continues to propose further cost-containment measures for the Medicare program."

In the Senate the same day, Special Committee on Aging Chairman John Heinz (R-Pa.) released a study by the General Accounting Office on the DRG system's impact on post-hospital care for Medicare beneficiaries. The study, Heinz said, shows that patients are being discharged "quicker and sicker," sometimes even "prematurely," and are "being sent out into a no-care zone, without access to the health care they so urgently need."

"DRGs are designed to squeeze the fat out of hospital costs without taking it out of the hides of older patients on Medicare," he explained. he added that it would be "unfortunate" for taxpayers and Medicare's 30 million beneficiaries "if DRGs are not working because hospital administrators are not living up to their end of the bargain. . . . My concern is with hospitals that continue to pad the flab with unnecessary procedures and sloppy accounting while tightening the belt on quality of care."

Noting that the DRG system does not limit hospital stays but allows hopsitals to retain savings if they treat patients for less than the set amounts, Heinz said the GAO study found that many patients are being told "improperly that they have to leave because their Medicare coverage has run out. Any hospital that dumps a patient because the 'DRG has run out' either doesn't understand the system or is misrepresenting the design intentionally out of greed."

He cited an 86-year-old, blind and diabetic constituent who was told his "DRG was exhausted" and was sent home with a "grossly infected" open wound after gall bladder surgery. But, Heinz said, the man still had several months of Medicare coverage remaining.

"We need to get hospitals on track fast," he added, "implementing the DRGs as Congress intended."

In addition to incidents of improper information about benefits, the GAO study found the following:

. Patients are being discharged after shorter lengths of stay and in poorer health than before the DRG system took effect.

. It is not clear that post-discharge care providers--including nursing homes, home health and community services--are equipped to care for the sicker patients.

. The DRG system is expected to increase the demand for post-hospital care, but nursing home beds for Medicare patients are already in short supply and coverage for home health and community services is limited in many areas.

. Increased demand for nonhospital services covered by Medicare will increase the costs for those services and will force beneficiaries to pay more out-of-pocket.

APPENDIX D

The Oldest Old
Ever More Americans
Live Into 80s and 90s,
Causing Big Problems

The Strain on Social Services
And Relatives Will Rise;
Should Care Be Rationed?

A Five-Generation Family

The Wall Street Journal, Monday, July 10, 1984
by Alan L. Otten

"A 76-year-old patient of mine died the other day," says Joanne Lynn, a Washington, D.C., geriatrician. "The real tragedy was that he'd been taking care of his 95-year-old mother at home, and now she has no one."

"An elderly friend of mine was in a nursing home for eight years," relates Ethel Shanas, a gerontologist at the University of Illinois at Chicago. "Her son was putting his own son and daughter through college--and, at the same time, having to pay some of her nursing-home bills. That's a lot of pressure to put on one person."

By now, almost everyone is aware of "the graying of America"--the fact that a steadily increasing percentage of the U.S. population is living past 65, the long-accepted benchmark for entry into old age.

What is dramatically new and worrisome about that fact is what one expert calls "phase two of the gerontological explosion"--the aging of the aged. As society learns better to stave off heart disease, strokes, cancer and other killers, more and more Americans, and an increasing percentage of the total population, are living not just past 65 but on into their 80s, 90s and beyond. Men and women 85 and over constitute the fastest-growing age group in the U.S.

The Problem Group

It is these "oldest old"--often mentally or physically impaired, alone, depressed--who pose the major problems for the coming decades. It is they who will strain their families with demands for personal care and financial support. It is they who will need more of such community help as Meals on Wheels, homemaker services, special housing. It is they who will require the extra hospital and nursing-home beds that will further burden federal and state budgets.

And it is they whose mounting needs and numbers already spark talk of some sort of rationing of health care. "Can we afford the very old?" is becoming a favorite conference topic for doctors, bioethicists and other specialists.

"Eighty-five is a kind of turnaround point," says Elizabeth Kutza, a social-policy analyst at the University of Chicago. "After that, the problems come faster: How healthy will I be? Who is going to be around to take care of me? How do I keep the income stream going?"

There are, of course, frail and ailing 60-year-olds and 70-year-olds, but most of today's "younger old" are healthy, active, relatively well-off--really more middle-aged than old. On the other hand, though a few Alf Landons and Ellsworth Bunkers remain active and alert in their 80s and 90s, somewhere in their 80s most of the surviving old begin to show their age.

"The average 85-year-old today has a longer life expectancy," says John W. Rowe of the Harvard Medical School, "but that life expectancy is dominated by disability."

Census Bureau figures tell the startling story. In 1940, only 365,000 Americans were 85 or over, a mere 0.3% of the total population. By 1982, the number had zoomed to 2.5 million, or 1.1% of the population. By the end of this century, only 16 years from now, the bureau predicts, this oldest old group will top 5.1 million, almost 2% of all Americans. By 2050, after the postwar baby-boomers have all reached the highest age brackets, more than 16 million men and women will be 85 or over, some 5.2% of the population.

Five Generations

By the year 2000, more than 100,000 Americans will be 100 or over, three times the present number. Four-generation families are already commonplace, and five-generation families have begun to turn up. James Birren, who heads the University of Southern California's gerontology center, tells of a friend who on the same day visited her grandmother in a nursing home and then baby-sat for her infant granddaughter.

The current surge in the ranks of the oldest old stems primarily from the increased numbers of children born and surviving in the late 19th and early 20th centuries, and secondarily from declining deaths from epidemics, heart attacks, strokes and other diseases that used to kill people in youth or middle age. Since 1900, average life expectancy at birth hs lengthened more than 50%--from 49 then to almost 75 today.

In the past few decades though, mortality rates for the elderly have been dropping faster than those for other age groups. Earlier changes in life style and improved medical treatment get the credit. Women have benefited especially; they are outliving men by steadily widening amounts. In 1980, there were 80 men for each 100 women aged 65 to 69, but only 44 men for each 100 women in the 85-and-over bracket. As Peter Morrison, a Rand Corp. demographer, puts it, "Aging is disproportionately a woman's problem in our society."

Even now, society knows comparatively little about the special problems of the very old. To begin filling in the gaps, the federal government's National Institute on Aging is proposing to underwrite dozens of research projects into the health, income, housing arrangements and other aspects of the life of the oldest old.

"The condition of the very old today is like an 18th-century map of Africa--huge areas marked terra incognita," the NIA's Richard Suzman says. "There isn't that much data, and the quality of much of it is terrible."

HEALTH

Even at age 85 or 90, today's elderly are unquestionably healthier and more active than their predecessors. As they become very old, however, they obviously are also increasingly likely to suffer from chronic illnesses or other disabilities that require increasing care for longer and longer periods.

"From the population of very old people come most of the million and more who are so disabled that they require round-the-clock care in nursing homes, the two million who are equally disabled but who are not in institutions, and many of the six million more who require less intensive services," says Elaine Brody of the Philadelphia Geriatric Center.

Among the most incapacitating chronic conditions are Alzheimer's disease and other types of mental impairment, with their progressive loss of memory, disorientation and inability to function alone. They become more common with advancing age and are the major cause of institutionalization.

Rising Risks

"Dementing illness roughly doubles every five years after 65," says Carl Eisdorfer, a geriatric psychiatrist who heads Montefiore Medical Center in New York City. "About 1% show it at 65, 2% at 70, 5% at 75, 12% at 80, up in the 20s at 85, and 40% to 50% in the 90s."

Other chronic problems that strike with increasing frequency and severity as the old grow very old include arthritis, limiting heart conditions and hypertension, and osteoporosis (brittleness of the bones). Incontinency, problems with hearing and vision, and depression and other mental strains also become common.

"But the real name of the game for the very old is multiplicity of illnesses," says Robert Butler, the head of the Department of Geriatrics at the Mt. Sinai School of Medicine in New York. "It gets called frailty and other things, but it's really multiplicity."

Heavy Demands

With chronic conditions added to acute health problems, the very old use medical resources disproportionately. Robert Binstock, the director of the Policy Center on Aging at Brandeis University, estimates that per-capita hospital spending of the 65-and-over group is more than 250% higher than that of the under 65s, with the 85-or-over group 77% higher again. The super-old also fuel the nursing-home explosion; the government says that only 6.4% of the 75-to-84-year olds are in nursing homes but 21.6% of the 85-or-over group are.

Finally, those very old who aren't in institutions still require lots of family and community care. Barbara Feller of the National Center for Health Statistics estimates that one in 10 men and women between 65 and 75 need another person's help in everyday activities but that four out of 10 need such help at 85 and over.

"People are undoubtedly living more healthy years," says Jacob Brody, an NIA associate director, "but the problem is they are living more unhealthy ones, too."

GOVERNMENT SPENDING

Barbara Torrey, a government economist who has studied the elderly, estimates that the government now is providing $51 billion in payments and services just to people 80 and over and that, by the year 2000, it will be paying $34.3 billion more (in 1984 dollars) solely because of the increasing numbers of the very old.

Medicare's hospital-insurance fund is currently projected to run out of money around the end of this decade. The chief cause has been inflation in hospital and other medical costs, but "the growing number of old people certainly exacerbates the problem," says Michael Boskin, a Stanford University economist.

The Reagan administration says there is an urgent need to either raise payroll taxes or reduce Medicare benefits. Both courses are politically explosive.

Only to a limited extent does Medicare help pay for nursing-home and other long-term care. Medicaid, a needs-based system financed partly by Washington and partly by each state, helps pay those costs for impoverished old folks, and it has been one of the most rapidly growing state outlays. Many states are trying to cut back eligibility, and a few are considering the possibility of making children pay at least part of the long-term care bills of their needy parents.

Many experts think that money could be saved by keeping frail old people at home rather than in institutions: more Meals on Wheels, visiting nurses and homemakers, and transportation services. "This is cheaper and more humane," argues Jack Meyer of the American Enterprise Institute.

Other specialists think that Medicare must ultimately be extended to cover nursing homes, community services and other long-term care. "Medicare was supposed to protect the elderly against catastrophic expenses," says Rosalie Kane of Rand Corp., "and this is the most catastrophic of all."

PERSONAL FINANCE

The current generation of old people, most economists agree, is generally far better off than any of its predecessors. They have more wealth in homes, cars and savings. Inflation-adjusted Social Security, private pensions and special tax breaks have increased their after-tax income. Twenty years ago, one in four over-65s was below the poverty line; now, one in seven is.

But the oldest old may find their pensions exhausted and health bills eating into savings. Mrs. Torrey says the average income of the 85-and-over group is at least one-third less than that of people between 65 and 70.

More and more, expert opinion is challenging the trend toward early retirement, questioning whether early retirees realize how much longer they are likely to live and how much more money they might need. The Senate Committee on Aging says the proportion of the average man's life spent in retirement has increased from 3% in 1900 to an astonishing 20% in 1980.

"People are going to need an enormous increase in their assets to maintain their standard of living for so many years," Stanford's Mr. Boskin says.

FAMILY BURDENS

Despite the widespread image of families dumping aged parents into nursing homes, surveys show that most frail elderly are still outside institutional walls and that a spouse, child or other relative is still the chief caretaker.

"Family responsibility is doing well so far, but can it stand up to all the strains and demands we may soon be putting on it?" asks Mrs. Shanas, the Chicago gerontologist.

Support for the very old may have to come increasingly from children approaching retirement or already retired and dealing with their own health problems. Many of the middle-aged may encounter simultaneous demands to support a parent in a nursing home and to put children through college. Daughters and daughters-in-law, the traditional caretakers of the elderly, are todayfar more likely to be employed, unwilling or financially unable to give up work to help an aged parent.

"Women used to drop out of the labor force to care for their kids," observes Cynthia Taeuber, a Census Bureau demographer. "Now, they're facing the need to drop out to care for an aged mother."

Divorce, remarriage, single-parenthood and other changes in family patterns all are blurring lines of family responsibility. For example, the high divorce rate lessens chances that an elderly woman--men are more likely to remarry after divorce or death of a spouse--will have a helpmate when she needs one.

Experts on aging also worry about the possibility of sharpened intergenerational conflict ahead, as low fertility rates provide fewer working-age taxpayers to meet the growing needs of the elderly.

BIOETHICAL CHOICES

Super-longevity and rising health-care costs have almost inevitably sparked discussion of rationing health care to the very old: no kidney dialysis or liver transplants after 55, for example.

"The problem is age-old and across cultures," says Dr. Eisdorfer of Montefiore. "Whenever society has had marginal economic resources, the oldest went first, and the old people bought that approach. The old Eskimo wasn't put out on the ice floe; he just left of his own accord and never came back."

Jerry Avorn of the Harvard Medical School says he now hears young doctors and interns say, "It's not cost-effective to perform that operation--he's too old." A group of 10 doctors recently published in the New England Journal of Medicine a set of guidelines on when to decrease "aggressive treatment" of the hopelessly ill.

Still, doctors and experts on aging overwhelmingly believe that the U.S. is still a long way from embarking on any formal rationing of health care by age. "It is very dangerous to develop age criteria for excluding people, and I'm dead against it," says Edward Schneider, another NIA associate director. Observes Dr. Avorn sarcastically: "Euthanasia at retirement would be the most cost-effective of all."

APPENDIX E

Policy Cited in Child Poverty
Moynihan Sees U.S. Aid Focused on the Elderly

The Washington Post, Sunday, April 7, 1985
by Juan Williams

Sen. Daniel Patrick Moynihan (D-N.Y.), whose call 20 years ago for a national policy on the family was criticized and ignored, says that since then the government has largely eliminated the plight of the indigent elderly while allowing the number of poor children to vastly increase.

In a speech to be delivered Monday at Harvard University, Moynihan says that "the rate of poverty among the very young in the United States had become nearly six times as great as among the old."

"During the '70s, owing in large measure to government transfer programs under Social Security, the problem of poverty greatly diminished among the aged, but intensified among the young," he says.

"No government, however firm might be its wish otherwise, can avoid having policies that profoundly influence family relationships. This is not to be avoided," he says. "It has been argued that the largest single change in the tax code since 1948 is the erosion of the value of the dependent deduction in the income tax, in consequence of which we now tax families with incomes below the poverty line."

"Poverty is now inextricably associated with family structure," he says. "Half of all poor persons live in female-headed households."

While offering few specifics for a family policy, Moynihan calls for a sizable increase in the income tax deduction for dependents.

Saying that, as a society, "We value self-sufficiency [and] we are offended by poverty," Moynihan contends that "It follows that we should not tax individuals, much less families, to the point where they are officially poor and potentially dependent. We now do that."

He also says, "More than three-fourths of median family income in 1948 was exempt from federal tax," and asks, "Was this not a powerful national family policy? It costs money to raise a family, and the federal government chose not to tax most of the income so required. This is no longer so."

In 1983 "less than one-third of the median family income was exempt," he says, adding that a poor family is now "subject to tax."

The senator, who is the ranking Democrat on the Senate Finance Committee's subcommittee on income-maintenance programs, also contends that basic welfare payments should be indexed to inflation.

Moynihan criticizes the book "Losing Ground" by Charles Murray, which argues that social programs have hurt rather than helped the poor. He is particularly critical of Murray's assertion that increased social spending leads to more social problems:

"From 1969 to 1980 AFDC [Aid to Families with Dependent Children] payments, in constant dollars, declined 56 percent," he says. "What were the effects? . . . In the large I see none. . . . This, in my view, is the final difficulty with the argument of 'Losing Ground.' The increase in dependency in the 1970s that so concerns the author, illegitimacy, single parents, took place, or rather continued taking place, while the value of welfare benefits was declining."

The senator defends the 1960s commitment to social programs as producing the "extraordinary achievement of this era--the near abolition of poverty among the aged."

He says that "indigence all but disappeared among the aged while it significantly increased among the young," due to the government's indexing Social Security and many other "entitlement" programs, with the prominent exception of AFDC. Moynihan says that in 1983 there were 13.8 million poor children (under age 18), compared with 3.7 million poor people over age 65.

APPENDIX F

Americans' Life Spans Increasing

The Washington Post, Saturday, March 23, 1985
by Cristine Russell

Americans are living longer, and the gap between the life expectancy of whites and blacks is narrowing. But infant death rates--while at a record low--are declining more slowly than before, and mortality among black infants remains about twice as high as that for white infants, the government reported yesterday.

"Our nation's 'health grades' are very good indeed," said Health and Human Services Secretary Margaret M. Heckler, as she released her department's annual report card on the nation's health. "And most important of all, further progress on almost every health front is indicated."

Heckler noted that life expectancy at birth reached nearly 75 years in 1983--"a record high." But, she added, "More encouraging is the fact that the longstanding disparity between life expectancy for white and black Americans is now narrowing."

The four-year increase in overall life expectancy achieved between 1970 and 1983 was greater than in the preceding two decades. While the increase among whites during this period was 3.5 years, up to 75.2 years, it was greater among blacks, with a rise of 5.5 years to a life expectancy of 69.6 years, the new report said.

Most of the recent life-expectancy gain came among middle-aged and elderly people. The government projects that, on average, Americans who reached age 65 in 1983 could expect to live another 16.8 years, or to nearly age 82. Those who turned 45 that year could expect to live another 33 years, to age 78.

Heckler credited the trend to healthier life styles. This also may have contributed to what she called the "remarkable progress against heart disease and stroke," with heart-disease mortality down 25 percent since 1970 and stroke deaths down almost 50 percent.

Health experts say they believe that the incidence of such deaths has declined, at least in part because of wider use of drugs to control high blood pressure, improved diet, increased exercise, less smoking and generally better preventive and therapeutic health care.

"There are, of course, lags and aberrations. We certainly cannot rest on our laurels," Heckler said in the introduction to the report, "Health, United States, 1984." In her news conference yesterday, she acknowledged two particular concerns: slowing progress in the fight against infant mortality and increased lung cancer among women smokers.

Heckler said the national infant mortality rate "continues to show improvement," falling to 10.9 deaths per thousand live births in 1983. Provisional data for 1984 shows a "further decrease," she said, to 10.6, about a 3 percent decrease.

Experts from the National Center for Health Statistics, which prepared the report, said that although often there is a fluctuation from year to year, the 1983 and 1984 numbers represent "the first time that we saw two slow declines in a row." They said that at least seven states were having particular problems.

Heckler said yesterday that the HHS would do more to prevent infant mortality, including measures ranging from spending available funds to sending Public Health Service "Infant Mortality Review Teams" to states that ask for help.

She said she would seek a new public information campaign to help inform women of the health consequences of smoking during pregnancy. Smoking can increase the chances of delivering a low-birth-weight baby who is more prone to early death, suffering complications during pregnancy and delivering prematurely. Yet, noted Heckler, 44 percent of married women with less than a high school education smoked during pregnancy in 1980, as did 28 percent of high school graduates and 16 percent of those who had completed some college.

Heckler contended that the country will succeed in meeting the U.S. surgeon general's 1990 goal of reducing infant mortality in the first year of life to 9 deaths per thousand live births. But she acknowledged that it would be "more difficult to achieve" the goal of 12 deaths per thousand births among minority infants. In 1982, the most recent year for which data is available, black infant mortality was 19.6 deaths per thousand births.

Congressional critics and groups such as the Children's Defense Fund question whether the United States will meet the 1990 goals. They have criticized the Reagan administration's budget cuts and say that more should be spent to care for pregnant women and their newborn children.

Heckler also noted that "lung cancer is rapidly approaching breast cancer as the leading cause of cancer deaths among American women. In fact, among those aged 55 to 74, lung-cancer mortality has already overtaken the death rate for breast cancer." About 30 percent of adult women smoke.

Other findings of the 188-page report include:

. Life expectancy. In addition to a narrowing in the racial gap, the life expectancy differences between the sexes is narrowing. Nonetheless, in 1983, female life expectancy at birth--78.3 years--exceeded that for males by 7.3 years.

. Infant mortality. Despite a nearly 50 percent decline since the mid-1960s, the U.S. infant mortality rate still falls behind most industrialized countries. There is wide variation among states, ranging in 1983 from 9 in Vermont to 12.5 in West Virginia per thousand live births among whites. Among black infant births, it swings from 16.4 (Massachusetts) to 25.9 (Illinois) in the 26 states with black populations of 150,000 or more.

The District has a higher black infant-mortality rate--26.3--than any state, as well as a higher white infant mortality of 13.7 (this may be unreliable because of the small number of white births). Despite this, Heckler said yesterday that recent improvements--a 35 percent reduction over three years--showed "dramatic progress."

. Motor vehicle accident death rates. Among males between age 15 and 24, the overall rate for whites--67.6 per 100,000 in 1981--was about twice as high as the rate for blacks--30.8. The rates were highest among white males in three states, Wyoming, Nevada and New Mexico; and highest among black males in Mississippi and South Carolina.

APPENDIX G

Local Differences in Health

This chart examines differences in standards of health among residents of the District, Maryland and Virginia. The final two columns show the highest and lowest figures noted for any state in the nation. Rates for victims of motor vehicle accidents, breast cancer, heart disease and stroke indicate deaths per 100,000 people in 1980.

Health Indicator	D.C.	MD.	VA.	State High	State Low
% white mothers beginning prenatal care in first trimester	77	85	84	90	63 % black
mothers beginning prenatal care in first trimester	63	69	73	74	49 Infant
mortality rates, white infants, deaths per 1,000 live births	13.7	11.2	11.7	13.7	9.0
Infant mortality rates, black infants, deaths per 1,000 live births	26.3	20.0	20.0	26.3	16.4
Motor vehicle accident death rates, white males, 15-24	12.8	65.3	60.2	114.5	49.7
Motor vehicle accident death rates, black males, 15-24	10.3	28.6	35.2	58.8	10.3
Age-adjusted breast cancer death rates, white females, 35-74	68.1	55.6	46.4	68.1	38.1
Age-adjusted breast cancer death rates, black females, 35-74	63.3	53.3	53.2	70.6	36.7
Heart disease death rates, white males, 45-64	492	513	522	641	308
Heart disease death rates, black males, 45-64	717	599	772	851	545
Heart disease death rates, white females, 45-64	169	177	154	232	93
Heart disease death rates, black females, 45-64	316	285	384	445	213

Health Indicator	**D C.**	**MD**	**VA**	**State High**	**State Low**
Age-adjusted stroke death rates, white males, 35-74	47.0	47.3	52.0	72.0	31.9
Age-adjusted stroke death rates, black males, 35-74	111.2	102.1	154.4	233.8	76.8
Age-adjusted stroke death rates, white females, 35-74	43.4	36.5	42.5	50.0	27.3
Age-adjusted stroke death rates, black females, 35-74	73.6	83.8	104.4	153.3	57.6
Patient care physicians per 100,000 resident population, metropolitan areas	423	217	179	423	122
Patient care physicians per 100,000 resident population, non-metro areas	---	124	93	207	53
Patient care dentists per 100,000 resident population, metropolitan areas	66	47	44	68	32
Patient care dentists per 100,000 resident population, non-metro areas	---	38	30	72	19
Average days spent in community hospitals	8.7	8.3	7.9	9.7	5.4
Adjusted expenses per inpatient day, community hospitals	459	329	282	508	217
% persons 75 and over, institutionalized in nursing homes	6.4	9.7	8.7	16.1	4.2
Medicare per capita reimbursements, persons 65 and over	2,290	1,800	1,320	2,290	1,130
Medicaid recipients per 100 persons below poverty level	51	50	29	104	17

NOTE: Prenatal care and infant mortality rates apply to 1979-1981. Death rates for motor vehicle accidents, breast cancer, heart disease and stroke are for 1979-1980. Patient care physician numbers are for 1980-1981. Patient care dentist figures for 1979. Figures for hospital stay/expenses and Medicare are for 1982; the Medicaid figures apply to fiscal year 1982. Figures on nursing home residents are for 1980. High and low figures not available for states with black population under 150,000.

SOURCE: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL CENTER FOR HEALTH STATISTICS.

COMPILED BY STAFF RESEARCHER JAMES SCHWARTZ.

The Washington Post, Saturday, March 23, 1985.

APPENDIX H

Older Workers Are More Productive, New Study Suggests

The Washington Post, March 26, 1986
Health Section, p. 5
by Wendy Melillo

Job performance may increase with age, according to a new study published in the Journal of Applied Psychology. This contradicts the prevailing belief that workers become less productive as they get older.

The traditional view that productivity declines with age has led to "the increasing rate of reported age discrimination cases over the last five years," the study found.

"A lot of people view the older worker as a poorer employee," said David Waldman, industrial psychologist at the State University of New York at Binghamton who coauthored the study with Bruce J. Avolio, an industrial psychologist. "This is a fairly prominent stereotype, especially in such a youth-oriented society."

To examine the relationship between age and job performance, Waldman and Avolio looked at 13 studies that had been done in management and social science research between 1940 and 1983. Based on the studies, they developed 40 samples of different types of workers (such as managers, supervisors, academicians and air traffic controllers) which were divided into two groups of workers: professional and nonprofessional. Job performance was measured by worker productivity and ratings by supervisors and peers.

Overall, little relationship was found between age and job performance. The study also found that:

. Employee evaluations by supervisors showed a decline in performance with increasing age for both groups. Apparently, supervisors tend to rate older people lower than younger people because of the stereotypes, Waldman said.

. When comparing professionals to nonprofessionals, supervisory and peer ratings were higher for older, professional workers than for older nonprofessional workers.

Waldman attributed this to the type of work professionals do, suggesting that people in stimulating jobs that allow development and growth may continue to improve with age. Nonprofessional workers received lower job performance ratings as they got older, presumably because they are in dull, nonstimulating jobs.

"The main implication is that employers should be very careful in using just age in any kind of employment decision," said Waldman. "We are saying age does not have much validity in predicting people's performance."